



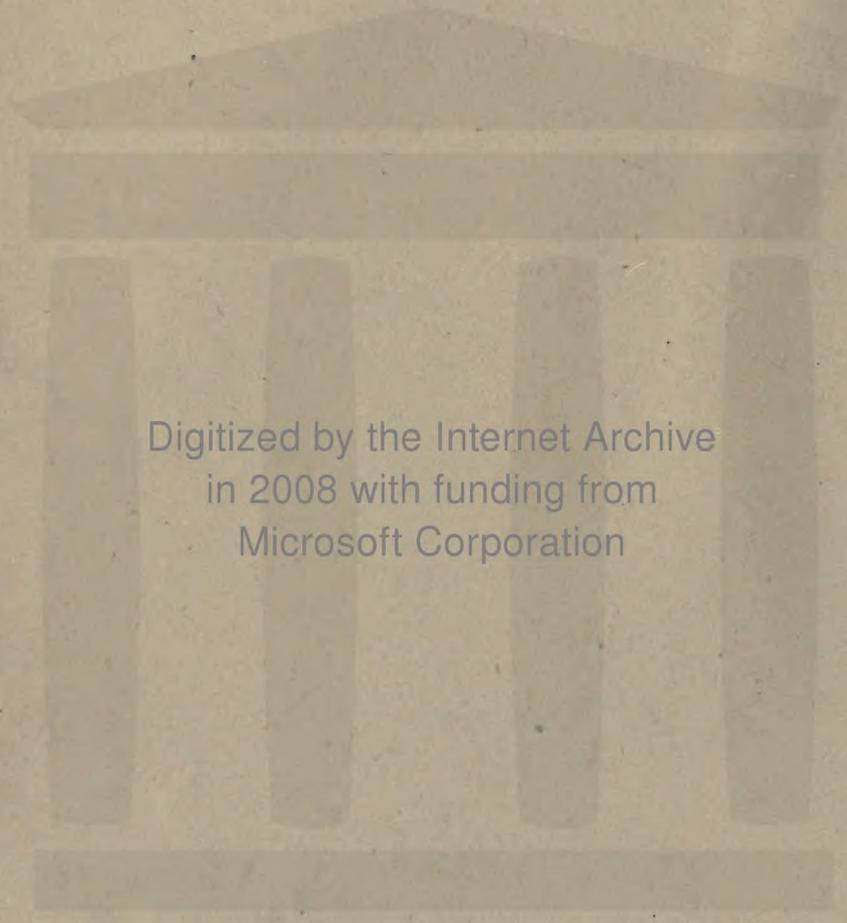
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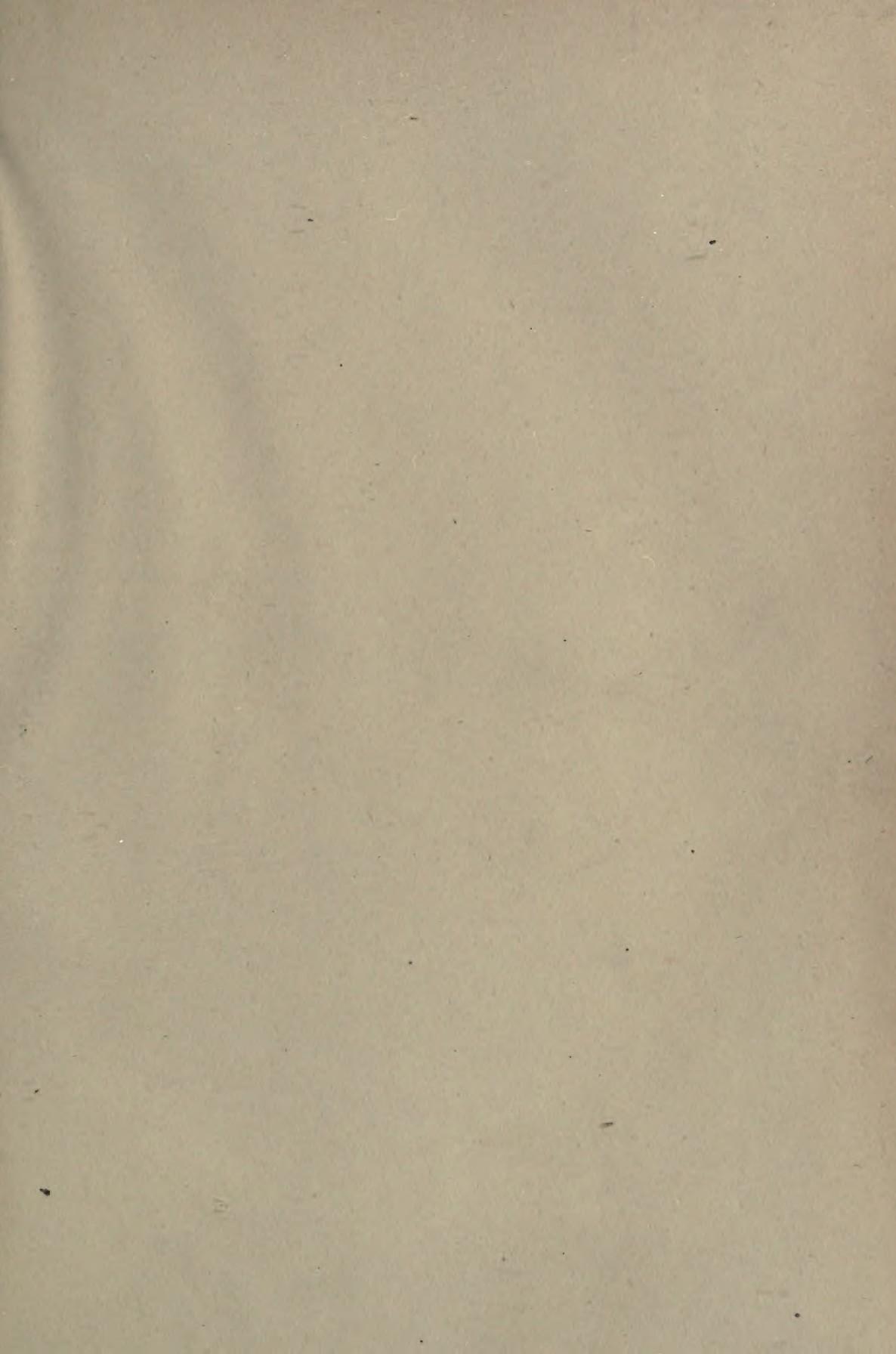
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THE HOSPITAL WORLD

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No. 1

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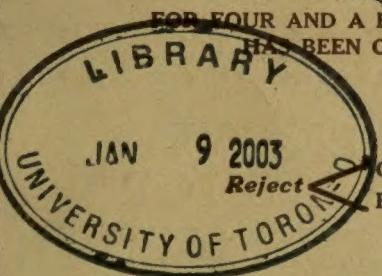
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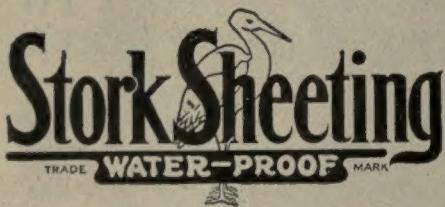
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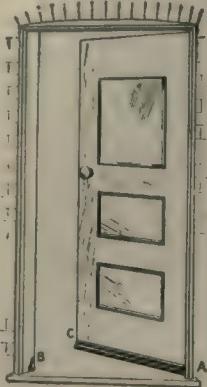
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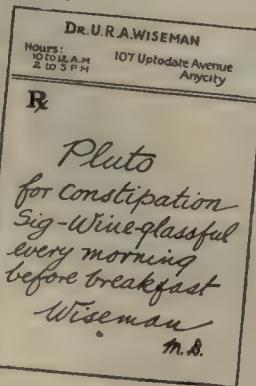
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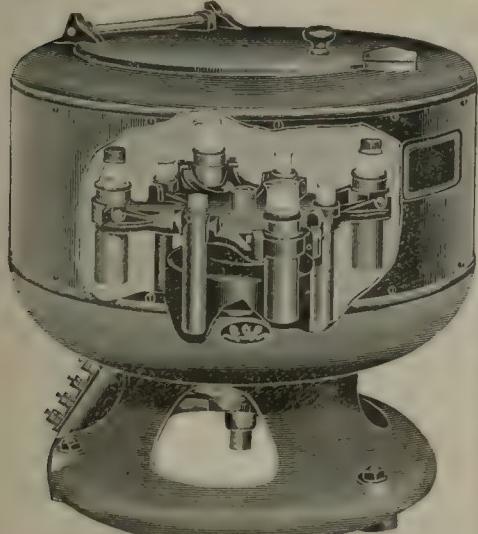
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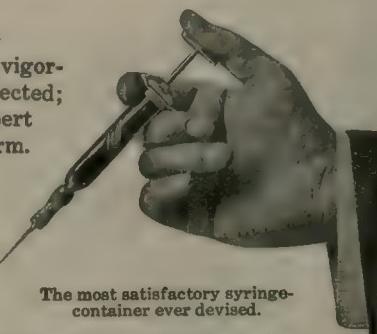
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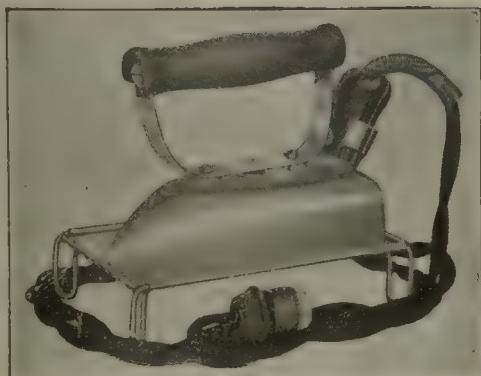
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No. 1

Editorials

DRUG ADDICTION

SINCE the putting into force in the United States of the Harrison Act, medical men, hospitals and sanatoria have been approached by many drug users and

besought to dispense to these unhappy victims the solace now denied them. This has brought to light many people who have been using narcotics clandestinely. The number of drug users is appalling, and only a very small percentage of our six thousand odd hospitals are prepared to take these victims in.

As before, these sick people are turned away. Few of them can afford to go to the regular sanitariums in which legitimate treatment is given, nor to the so-called institutes where for \$100 to \$500 an alleged cure is administered.

Why is this the case? One reason is that the average physician knows little or nothing of drug addiction. He has had no instruction in this branch in his medical course at college; nor has he had an opportunity of learning anything about it in the post-graduate schools. Literature on the subject is scarce.

In addition to ignorance of the etiology, clinical picture and treatment of drug addiction on the part of the average hospital physician, few hospitals are equipped for the rational treatment of these cases, which are as amenable to treatment as sufferers from many other diseases.

These cases need segregation, quiet, eliminative, alterative (to use an old term) diet, water and occupational therapy, and a large measure of psychotherapy.

Where is the hospital that has the simple hydrotherapy outfit, or any occupational apparatus and material, or a physician who is trained in psychology?

Meanwhile, mercenary fake establishments flourish. In some the patients are purged until colitis is produced; belladonna is pushed to the point of delirium, and the victims are cowed by rough attendants, and patients are discharged with the assurance that they are cured; that if they suffer a relapse it will be their own fault; that they never need seek entrance to the institution again. These hospitals make an individual study of the patient and apply the line of treatment above alluded to.

Other hospitals must follow the lead of these two, and by making provision for the study and treatment of these cases, take them out of the hands of unqualified practitioners and charlatans.

Provision must also be made for the after care of these patients. We know of nothing better than a farm provided not only with the implements of husbandry but with workshops in which many light and agreeable occupations may be carried on.

A few weeks, or maybe months, will work wonders in bringing these poor wrecks of humanity back to their former selves.

It is good to know that this condition of affairs will not be permitted to endure much longer. Rational hospital treatment is being introduced.

MEDICAL EDUCATION IN THE UNITED STATES

THE *Journal of the American Medical Association* for August 21st contains its annual review of the above-named subject. The article is illuminating and affords gratification to all those interested in the progress of medical schools and hospitals. The improvement of the medical school spells improvement of the attached hospital.

The report shows that the college which has widely distributed alumni usually has a student body from an equally large number of states. New York State furnished 1,948 students, Illinois 1,318, Pennsylvania 1,140, Nevada furnished 4, foreign countries 458. There was an attendance of 3,373 freshmen, as compared with 4,684 last year, which shows the effect of the higher standard of entrance. The total number of students enrolled was 14,891—1,611 less than last year, and 13,251 less than the year 1904, when the campaign for fewer and better colleges began. The total number of graduates this year was 3,536; the total number in 1904 was 5,747. Degrees in arts or science were held by 858—24.3 per cent; 592 women studied medicine in 1915; in 1904 there were 1,129. There are 95 medical colleges; in 1906 there were 162, one-half the world's supply; 92 medical colleges have ceased since 1904—52 closing by merger, 40 becoming extinct.

While the total number of colleges is growing smaller and approaching more nearly the normal

supply for this country, the high-grade, stronger medical colleges are constantly increasing. In 1904 only 4 medical colleges required any advance of the usual high school education; now 83 require advanced college work, 39 of which specify two years or more of collegiate work.

There are still 16 cities in 14 of which mergers are possible. These are: Chicago, with 8; New York, with 7; Philadelphia, with 6; Boston, with 4; San Francisco, with 3; St. Louis, with 3; Washington, with 3; and two each in Ann Arbor, Baltimore, Cincinnati, Columbus, Iowa City, Los Angeles and Omaha.

The largest first-year classes are found at the University and Bellevue Hospital Medical College, 150; Columbia University, College of Physicians and Surgeons, 132; Rush Medical College and the University of Michigan, each 100; Harvard, 98, and Johns Hopkins, 91.

There are 66 Class A schools, 17 Class B, and 12 Class C. In Class A fees range from \$150 to \$275 per year for each student; the actual expense for teaching that student amounts to two and three times these sums. Accurate data secured from 65 medical colleges shows that the average amount received from each student each year was \$138, while the average amount actually expended in the training of that student was \$382!

Many Class A colleges have only from 7 to 75 students in each class, or totals of from 50 to 300

enrolled, when they could easily care for 200 to 400 each, at practically no additional expense.

The report points out that it is encouraging to note that 76 per cent. of all students were enrolled in the 64.4 per cent. of colleges which are in Class A, and that these colleges turn out 74.4 per cent. of all graduates.

These quite wonderful figures show what has been done by the Council of the American Medical Association on Medical Education, and also by the compilers of the two well known Carnegie reports.

It now remains for the Association through its hospital section or some wealthy man to do for the hospitals of America what has been done for the medical college situation, and that largely by securing the facts and publishing them.

Pulitzer, the great newspaper magnate, made his paper a success on the principle that the only hell feared by the modern man is public opinion; so his reporters dug up the facts, ugly as they were, and published them; the papers sold, and the advertisers sought the medium so widely spread.

The medical colleges were shown up in their rottenness, and the very exposure proved their damnation.

So it will be with the hospitals, in many of which incompetent surgeons are doing their deadly work; innocent nurses are exploited to save the payment of competent nursing and housekeeping help; institutions are run for the aggrandizement of medical men;

work is carried on in fire-trap buildings, of unsanitary construction and inferior equipment.

There must be a clear line of demarcation between the hospital efficient and the hospital non-efficient, and the public must be kept informed of the ranking of each.

PRESERVING FRUITS

MANY hospitals are in the habit of buying tinned meats, canned fruits and vegetables. This is poor economy. Patients require fresh vegetables and fresh fruits in season. Out of season it is better that fruits and certain vegetables should be provided which have been put up in sealers by the steward or the housekeeper in the hospital kitchen or bakery. This is cheaper than buying the goods sold in metal tins, and is infinitely more wholesome for patients and employees.

Original Contributions

LITTLE JOURNEYS

BY DR. JOHN N. E. BROWN,
Superintendent, Henry Ford Hospital, Detroit.

THE ROBERT BARNES HOSPITAL, ST. LOUIS, MO.

THE BARNES HOSPITAL at St. Louis is of the pavilion type. The medical and surgical buildings are three storeys in height with a roof garden and basement. The roofs are not provided with service rooms.

The shape of the medical and surgical wards is that of a capital T, the leg of the T representing the ward itself and the two arms the headhouse. A general corridor runs through the centre of the headhouse and at right angles to the ward.

The basement of the surgical building contains a pair of disinfecting rooms, the sterilizer passing through the intervening wall; a trunk room; a locker room for patients' clothing; a soiled linen room running up from which is a clothes chute which connects with the utility rooms of each ward unit.

The first floor of the surgical building represents a typical ward unit of both medical and surgical pavilions. The vertical arm of the T forms the ward proper, and just across the general corridor from the ward are three small isolation wards; a bathroom, a sinkroom, patients' and nurses' toilets; a laboratory and a surgical dressing room.

On entering the ward, on either side are the service rooms. On one side is the kitchen with the day room next it, a door connecting them. On the other side of the entrance is a small corridor leading to the utensil room. Off this corridor is a door leading to the patients' bathroom. On the wall between this sub-corridor and the general corridor and on the wall of the utensil room are found an enemata closet, a drying closet. In the main corridor there is a cleaners' closet. In the end

of the ward just to the right of the entrance is a shallow built-in linen closet. On the other side are a medicine closet and a closet for supplies. A door opens from the utensil room into the main corridor which makes it convenient for nurses working in the three wards across the corridor and in the two isolation wards which lie side by side next the utility room. In the bathroom is a shower as well as a tub. Off the service rooms on each side of the ward and running at right angles to the ward are two covered porches corresponding to the two arms of the T. At the other end of each porch is a fire-escape.

THE LAUNDRY.

On the first floor of the laundry are located the room for the reception of soiled linen, a large wash and mangle room, and beyond these is the delivery room. Next to the delivery room is the sewing room. In connection with the receiving room are the disinfecting rooms, and store room. The disinfector penetrates the wall between the disinfecting rooms and in each of these rooms there is running water. Toilet accommodation is provided on this floor for both sexes.

On the second floor of this building are found the men's dormitories, but these do not extend over the wash room. A roof light is placed here instead.

SPECIAL TREATMENT ROOMS.

In the basement of the medical pavilion is a hydro-therapeutic department, a large room for mechano-therapy, and two large rooms for electro-therapy. There are besides these a students' locker room, a waiting room, an examining room, an attendants' room, dressing cubicles, a clean and soiled linen room, and a janitor's closet.

THE SERVICE BUILDING.

In the basement of the service building are three kitchens; one for the private ward patients, one for the public ward patients, and a diet kitchen. Leading to these is a passageway which expands centrally into an ample concourse. The kitchens

are provided with supply rooms, refrigerators, sculleries, etc. The general store rooms are near by.

The floor above—the ground floor—contains the dining room for nurses, male and female help, the doctors, with their respective serving pantries; and the matron's office. The food comes up from the kitchen to the serving pantries by means of a lift. All these floors are covered with linoleum.

The stories above are divided into dormitories for the help—the second is for women, and the third is for men. These floors are provided with necessary bath and toilet rooms. The roof is used as a promenade.

THE PRIVATE PATIENT BUILDING.

The corridor connecting the pavilions terminates in the Private Patient Building—a little to the right of the centre of the building.

The main corridor of this building runs at right angles to the connecting corridor. The ground floor contains 13 bedrooms, a waiting room, separated from the office by a counter; a receiving room, and service rooms. Eight of these rooms have private baths. The rest of the rooms have common bathroom and toilet accommodation. There are no closets in the rooms. Running parallel with the entrance corridor, is a service corridor. Off this corridor are the toilets, cleaners' closets, utensil rooms, and freight elevator.

The floors in the corridors are of tile; those in the rooms are of wood.

ADMINISTRATION BUILDING.

The administration and receiving buildings are placed one behind the other and are closely connected. In the basement of the front building—the administration—are the drug storage room, general store room, central linen room, room for housekeeper's stores, and a room for patients' street clothes.

In the basement of the rear building are the rooms for general kitchen supplies; refrigerating machinery, work shop, unpacking room, steward's office, toilet and locker rooms for the accommodation of the hospital employees, storage room for vegetables, meat, and block ice; and also a butcher shop. On

the ground floor of the main building are the administration offices,—five offices being located on each side of the entrance; a vestibule with small waiting rooms, vaults, toilets, and lavatories. Besides these rooms there is a foyer about 75 x 60 ft. with a marble floor. It is partly lit from the top. Off the foyer are toilet rooms for both sexes. On the same floor there is a suite of rooms and offices for the medical director, and a room for the trustee board and the secretary, with a lavatory and toilet. There is also a cleaners' closet and a passenger elevator about 8 x 12 feet.

The corresponding storey of the rear building is connected with the front one by a wide corridor and is used as a receiving unit and casualty department. It has three entrances, one to the surgical unit, one to the detention unit and one to the general receiving ward. Back of the general receiving room are two wards, one for men and one for women, each containing four or five beds with toilets and sink rooms. The detention unit contains two isolation rooms and a kitchen. Near the central entrance are three rooms,—two set aside for social service work and the other for the doorkeeper's office. This last mentioned room opens into both corridors. Just in the rear of this office is a commodious stretcher room, also opening into the two corridors.

The operating suite consists of two operating rooms with lavatories and sinks, a sterilizing room and an etherizing room. Between these two last mentioned rooms is a short corridor which connects the general receiving ward with one of the emergency operating rooms. Opposite the operating suite, across from the general receiving ward, are four examining rooms. These are separated from the general receiving ward by a sub-corridor. Each of these rooms is about 12 x 9 feet, and has running water in it. In connection with this unit there are two store rooms, a clothes chute, and a janitors' closet.

On one side of the wide corridor which connects the admitting department with the administration department is a room for appliances, and on the other side is a passenger elevator, a freight elevator, and a large store room.

On the second floor of the administration building are quartered the house officers. Here also is a clinical record room.

The corresponding floor of the rear building is devoted to roentgenology, and a laboratory with small wards and accessory rooms for the study of metabolism.

The roentgenology department has the usual rooms for X-ray work, screen room, dark room, waiting rooms, dressing rooms, and photographic department. Both these units—the metabolism and roentgenology departments—have the usual toilet, linen and other rooms. Operating room number one is separated from the amphitheatre by a surgeon's washup—with four bowls—and an etherizing room. These two rooms serve both the amphitheatre and operating room number one. This same arrangement holds true for the two operating rooms on the opposite side of the amphitheatre. This battery of four operating rooms is lighted from the north side and also from the roof.

A twelve foot corridor lighted from above separates the aforesaid battery of operating rooms from the house staff washup, students' gowning rooms, instrument room and two recovery rooms. On the same floor is the cystoscopic room and laboratory. Just across the corridor from the operating rooms lie the nurses' work room, the sterilizing room, and the room for the preparation of dressings. There is also provided on this flat a waiting room and three large examining rooms. Both freight and passenger elevator service extends to this floor.

The writer wishes to acknowledge his obligations to Dr. Charles E. Baur for his great kindness in devoting one of his busy days to showing our party about; also to Dr. Murphy, surgeon-in-chief, for hospitality extended and information relative to medical organization.

Society Proceedings

THE AMERICAN HOSPITAL ASSOCIATION

(Continued from November issue.)

Round Table Conference.

Dr. Franklin: My question this morning was whether our hospital of 250 beds, with an average daily attendance in the hospital of 225, an interne staff of about seven, with one paid interne who is at the head of the staff, usually selected for the second year, having made the best record for the previous year of the number, would it be practicable to have a lady interne as one of the six? We have the work divided into services of at least two months. Just to be understood, let me explain. On the first floor of our building we have 85 patients daily. That is railroad service. We have pay patients, male and female. All the railroad patients are male. It strikes me that this woman could fit in on the medical floor—we have both male and female service—and then in our surgical division, where we have the same thing. It seems to me that she could do satisfactory service in the laboratory and in the anesthetic work and in assisting in the operating room, so that I feel we have six months' service in which she could serve satisfactorily, and that there are six months in which she could not give satisfactory service. Would it be practicable under such circumstances for this lady to be appointed as interne? I have the question before me now, and that is why I am asking.

Dr. H. O. Spaulding: I will say that I was an interne in a hospital where there were four internes, two women and two men. The women internes could not do the ambulance service, and as to their ability to carry on the work, it depended a great deal on the individual. There was one woman whom I have in mind who stood up and did a man's work, except for the ambulance, perfectly satisfactorily, except, of course, in the care of certain of the male patients. I have at the present time

out of eight ward physicians in the state hospital three women physicians. It is a rather large number. The main objection, it seems to me, is that the service is not so elastic; that is to say you cannot shift them from one part of the hospital, or from one service to another, if emergency requires. I have found them, as a rule, exceptionally good in carrying out detail work. I do not think that it would be satisfactory to put them in charge of a service, especially where the male internes are subordinate. Somehow or other the men do not take kindly to that position. But I think it is possible to use one woman physician among your seven internes and get good service. There are some cases that she will probably get hold of better than the men. I have found it fairly satisfactory to have about one.

Dr. Holt: Will you tell us, Dr. Seem, what you are doing at Johns Hopkins in this respect?

Dr. Seem: We usually have a number of women on our house staff. I cannot remember that any woman has ever served on the surgical staff. Each year we have one on the medical staff, and she has charge of the women's medical ward. During the past year we have had a woman who has acted as assistant resident on the obstetrical staff. It has been her third year in the hospital in that service. We usually have one on the children's service, and we have had them on the psychiatric side, also in charge of the women patients, and then they have served on the gynecological service. Of course you have to have separate bathrooms for them, and the rooms which they occupy are not off to themselves; they live on the same corridor where the housekeeper lives. I think that is the main trouble.

Dr. Holt: Is there any other superintendent who has female internes in his or her institution?

Miss Jaquith: In my hospital I have six women internes, and we have always had women internes. Before I lived there I was in a hospital where they had men internes, so I have had both. I have never had them mixed, but I have had them separately, and I feel that the woman interne will do just as good work for you, if she has physical strength, as the man. She may do better work sometimes than a man, but, of course,

the personal equation has everything to do with it in both cases. I really do not know how I should like to mix one woman with a number of men in that way, because I do think it might be a burden to you to provide for her, as has been suggested; but as far as doing the work for you, I think you might find it satisfactory.

Chairman: Is there anyone else who wishes to speak on this question? I understand that at the Cook County Hospital in Chicago they have both male and female internes. As a recent comer there, I am not prepared to tell you how they arrange it. The question has come up at the Michael Reese Hospital, where I have recently gone. We have had applications from women, and the Interne Committee informed me that they had four at the County. Perhaps someone from Chicago can tell us under what conditions they are there. If not, I will ask the secretary to take up such questions as are ready.

Question 1. What is a hospital day? Is it a rule to count each calendar day as a full day?

Chairman: Will someone answer this question? Dr. Burlingham, have you anything to say, can you answer that?

Dr. Burlingham: I do not fully understand that question. Is it in regard to the payment of the patient's board, or in reference to the making up of a per capita cost?

Dr. Bunn: I can answer the question. It is in reference to the payment of a patient's board.

Dr. Burlingham: There are hospitals wherein a charge is made for the day the patient enters and the day the patient leaves, although they may stay only a part of each of those days. Then there are hospitals that count the first day, but do not count the day of discharge. Of course at hotels you pay for exactly the time you are there. That seems to be the most satisfactory plan, although I have known patients when they got used to the system to be willing to pay for the day of admission and the day of discharge also.

Dr. Warner: That question was discussed quite at length in the Cleveland Hospital Council, because one of the first things that we took up was some method to measure each hospital service to the community, and we endeavored to deter-

mine what the hospital day should be. The same question that Dr. Burlingham brought up also came up and was decided by the Council in the same way, that the payment for a private patient should be as for a hotel—that is, payment for the actual time—but it was the decision of the Council that the service to the community would be best measured by counting parts of days as days, because of the unusual and greater expense involved in those days of admission and discharge.

Chairman: I would like to hear from some of the lady superintendents in regard to this. Miss Prindiville, what do you do at your hospital in regard to counting the days?

Miss Prindiville: We count the day that the patient is admitted, but not the day of discharge.

Chairman: I will say that at the Boston City Hospital we used to count parts of days for days for patients occupying private rooms, but full days for those paying for ward accommodations.

Mr. Bishop, Pennsylvania: I should like to ask what the custom is in regard to figuring the per capita cost. I know that at a number of places, if a patient comes in in the evening for treatment, say at six or seven o'clock, and may go home the next morning at eight or nine o'clock, the hospital is credited with two hospital days, because the patient is there on a portion of two different days, although he has been in less than twenty-four hours. This would give the hospital a considerably smaller per capita cost.

Question 2: What responsibility has a hospital for the social life of the nurse? What are the hospitals doing in this respect?

Miss Barrett: At the hospital where I am superintendent we have a woman's board, and under this board they have a committee appointed for arranging for the social life of the nurses. They arrange entertainments, automobile rides, parties and that sort of thing. It has been quite satisfactory.

Miss Carrie M. Hall: This question has been most fully answered by Miss ——— in a paper this week before the National League of Education. The paper will be printed in the annual report. The experiment of having a social director

in the nurses' home has been carried out for more than a year in the Newton Hospital, and carried out most satisfactorily. It is their principle that the social director should be a young woman who is not a nurse and brings into the atmosphere of the nurses' home a point of view other than that of the nurses. She is, in this instance, a college woman and a woman who has had experience in directing both physical and social activities in other institutions. She has established a branch of the Young Women's Christian Association among the pupils. She has increased their library facilities by having the hospital training school made a substation of the city library. She has arranged evening entertainments and has insisted upon outdoor exercise, and has in very many ways increased the social activities among the nurses.

Miss Atkinson: We have on our board of managers a committee appointed, such as Miss Barrett described, to take care of the social side of the nurses' life.

Chairman: Miss Leck, have you anything to say about this?

Miss Leck, Detroit: After the study hours are over for the year, the classes take up the entertainments for the summer to a certain extent. There will be the senior and the intermediate, and the junior, and the probationer classes, and I ask the nurses to stay in one evening during the week, and during that evening each class entertains in turn. I think that is a very good idea to keep them in during the summer months. The idea of having the nurses affiliated, perhaps, with the Young Women's Christian Association, I like very much. Where I was before, we did that, and very successfully. When the Young Women's Christian Association had any special entertainment the nurses were always invited, and that broadened their interests.

Miss Wright: I am not a member of this association, but I am keenly interested in the social life of nurses. (Chairman: We will be very glad to hear from you.) I feel that, perhaps, during the long nine months of study and classwork, that they become, perhaps, to their private patients rather shoppy, talk too much of hospital affairs, and I have found that they very much appreciate having a woman come in from a woman's club;

a woman who, perhaps, is chairman of the current events section. I have had such an arrangement, and the nurses looked forward to that evening very greatly, as an evening where they relaxed, a perfectly charming woman who was keenly alive to all the topics of the day, and brought them an interest which the patients got the benefit of during the week.

Question 3: What is the best method of organization for a woman's auxiliary? Is a woman's auxiliary a source of strength or a source of weakness to the hospital?

Mrs. Horner: I have heard a good many people speak about the woman's auxiliary as rather a drawback, but, speaking personally, I know that I get very many things for the hospital, the patients, and the nurses that I would not get if I did not have a woman's auxiliary which was very much interested in every phase of the hospital work.

Chairman: Will not someone else who has a woman's auxiliary kindly favor us?

Miss Robinson: I can say for the woman's auxiliary that they are always a present help in time of trouble, a fine body of motherly, capable women. They have about ninety members, thirty of the ninety being very active. For years they have furnished our linen and many other things that we need, and whatever emergency arises at the hospital in the way of things which we need, and in the clinic, they stand by us and get for us. Just within the last few months they have raised \$3,500 for us for the furnishing of the nurses' home. They are certainly a source of help in every way.

Miss Butterfield: I cannot answer the question as to what is the best form of organization, but I can give our experience with the woman's auxiliary. We have a woman's board who have no executive powers, but are only advisory. They are elected by the board of trustees, and are of equal number, fifteen trustees and fifteen members of the woman's board. We find that with that relationship existing we get the highest use from the women; that is, they act as a sort of buffer between the hospital and the community in the fact that they help create a favorable impression for the hospital. We find that in the direction of the nurses' social life they can give admirable ser-

vice, and they can help in many ways to furnish the form of social life that is ordinarily given in hospitals. They have been in use in such matters as furnishing the nurses' home, even in furnishing the hospital, things where taste is concerned, there they are a great aid; and we also find that their inspections, which are not on regular days, are quite a stimulus to the members of the hospital force in keeping up appearance and by giving us an outside viewpoint that we could not get in any other way.

Miss Prindiville: I would like to say a word about the ladies' auxiliary. One has been started at the hospital where I am, and now we have one hundred and five members of the leading ladies of the city. They do not visit the hospital, they interfere in no way with the management of the hospital, but they aid in furnishing the linen, in making the curtains and various other things for the hospital, and they have been a great help. They meet once a month, and sew for the hospital. I find them a great help.

Miss Smiley: I have both a ladies' auxiliary and a ladies' aid, and they have done a great deal for the hospital in every way. They not only furnished the nurses' home, but purchased the land and purchased the home for sixty nurses and ten attendants. They are, at present, engaged in raising money for adding a children's department to our present hospital. They make weekly visits to the hospitals, both ladies' societies, but on different days. There is no set day. They look into the wards, see how the patients are taken care of, not interfering, but just in an interested way. Both societies do all that they can to furnish anything that the hospital requires. We also have ladies on the training school committee from these societies. It works very well.

Miss Barrett: In connection with our hospital, we have a society which has a membership of, I think, three hundred members. They have tried to care for all the linen of the hospital. One feature which they carried out was a very large fruit shower, which they took care of during the strawberry season and continued during the summer, canning and preserving the fruit. I cannot give you the figures as to just what

they gave us last year, but it was a very great help in furnishing good fruit for our patients. Perhaps they do not always accomplish as much as they plan to do—they plan to sew, and I find they do not do a great deal of work—but I think the greatest benefit of an auxiliary to a hospital is the fact that there are more people interested in it, and interest in the work is spread among the community.

Mr. Hall: I am not now connected with a hospital which has a ladies' board. I have been connected with a hospital which had women as members of one sort or another, and I have been connected with one hospital which has women on its board of trustees; but it seems to me that the women have a very definite place in the hospital management. However, I think their duties should be very clearly outlined; they should know exactly what their responsibilities are, where they begin and where they cease, whether they have a responsibility concerning the training school, or whether they have a responsibility concerning the supplies of the hospital. I believe in an advisory board of women for the training school.

Dr. Campbell, of Oklahoma: I wish I had something of that kind in my hospital. I have no experience with ladies' aids or ladies' auxiliaries. I am getting some good data now on these points, and will go home and put it into effect.

Dr. J. B. Franklin: We have a ladies' auxiliary. It was organized by authority of our board of trustees. The auxiliary has committees to represent the different activities, the linen committee, flowers, other committees, and these committees meet and give aid from time to time in these various departments. They help wonderfully. I find them in these matters a very great help.

Mr. Spaulding: At the state hospital, of course, there is no ladies' auxiliary. Two out of the seven trustees are women, and I find that they are a good deal of help, and in certain details of the work their advice is of a great deal of value. I have no experience, however, with the auxiliary board.

Chairman: Dr. Summersgill, what are you doing in the west in this respect?

Dr. Summersgill: At the hospital, at present, we have ladies, not connected officially with the board of trustees, but simply desiring to work in connection with the social service department and also the departments of maternity and pediatrics. They show a good deal of interest in the hospital, and are very charitably inclined. At the University of California Hospital the board is in its infancy, so I will not say anything about it. It has only been started during the last few months. On the whole, I think the auxiliary board depends upon how their duties are regulated, what they are expected to do. In some hospitals, the ladies' boards practically run the institution, although there may be a superintendent under which the board exists. It is, of course, rather a detriment than a help then. When the ladies' boards appreciate and understand their position in relation to the institution, in so far as giving assistance and rendering aid, they are of very distinct value.

Question 4: What should the dietitian's work consist of? Does the care of the dining-room come under her supervision?

Chairman: I think this was asked by someone who wanted Miss McCullough to say something on it, so I will ask Miss McCullough to open the discussion.

Miss McCullough: I think the dietitian should be responsible for the dietary department and everything included within it. That, of course, would take in all of the dining-rooms, the entire food problem, both in the preparation, in the care of it, and in the serving of it. If she is at the head of the department she can keep her finger on all the items at one time. I cannot understand the dietitian who would not have charge of the dining-room and the whole food problem.

Chairman: Have we any dietitians here who will favor us, besides Miss McCullough?

Dr. Warner: I just wanted to add that I made that change in the last year and the saving, I am very sure, is paying that dietitian's salary several times over; I mean making the department include the full dietetic work of the hospital, the storing of foodstuffs, the cooking of foodstuffs, the transportation of foodstuffs, the serving of food and the supervision of garbage. I am quite sure there is saved the salary several times over.

Dr. Burlingham: I do not think that I have anything further to say, except that we have rather preferred to keep the garbage inspection in the hands of the housekeeper instead of the dietitian. It is just the way that we prefer to do it. It has nothing in particular to do with the department. I see no reason why it should not work perfectly well for the dietitian to do it.

Dr. Seem: The garbage inspection with us is under the dietitian. One of her assistants inspects the garbage every day and one of the members of the resident staff attends with her once a week.

Chairman: Are there any other questions to come before the meeting?

Miss Barrett: I should like to ask if it is considered that the dietitian should do the purchasing for her department?

Chairman: Miss McCullough, will you answer that, please?

Miss McCullough: I think that is a question for the administration. Some dietitians do purchasing, and do the entire work. In other hospitals the superintendents prefer to do it. I think that in all such questions the dietitian should be considered, because she is responsible for the per capita cost of food.

Chairman: I think Dr. Summersgill, we have exhausted the questions.

Acting-President: I have an announcement to make, which is that to-morrow night we will again combine the Small and Large Hospitals Sections. Only one stenographer appeared, and in order that we may have the transactions of all our meetings we shall have to combine the meetings.

Dr. Holt: May I ask if any communications have been received from the American Medical Association with regard to their commercial exhibit. They have a very nice one, and I think the exhibit would be glad to have the members go down and see it.

Acting-President: We have received no invitation. In fact I inquired on the opening day, and they said that no one would be permitted to enter the exhibits unless they had an American Medical Association membership. The meeting is adjourned until to-morrow.

Hospital Notes

MRS. McCREA, of 510 Brunswick Avenue, Toronto, who successfully conducted a private hospital on Robert Street for several years, is prepared to receive elderly infirm and slightly feeble-minded ladies. Home comforts, care and attention given with due consideration. Nursing when required. Special attention given to diet, etc. Rates from \$10 up. 'Phone Hillcrest 913 (take Dupont car).

THE MILITARY HOSPITALS COMMISSION

IT has been found that there are quite a large number of soldiers who have been invalided home and who have been discharged at Quebec prematurely. The Military Hospitals Commission have, therefore, very wisely decided that these soldiers shall be again placed on pay and allowance, and will be treated exactly as if no such discharge had been given them, until the Medical Board has again pronounced upon them and they are declared fit to be returned to civil life or until they have been placed on pensions.

HOME FOR CONVALESCENTS

THE King has expressed a desire that the new convalescent home for Canadian soldiers at Upper Lodge on the Royal estate, Bushey Park, which had been placed at the disposal of the Canadian Medical Corps by His Majesty, shall be known as the King's Canadian Red Cross Convalescent Hospital. The accommodation is for 320, and it opened on December first.

Recently a Canadian convalescent home, accommodating 500, was opened for Canadians at Burwood, given by John Walter, member of the famous family that once owned the *Times*. He is a paper maker. Dr. Woodhouse, of Port Arthur,

is in charge. Hillingdon House, Uxbridge, is another Canadian convalescent home just opened. It accommodates 125, and is in charge of Col. McPherson, Toronto, who has just returned from France.

On November 15th the Canadian medical authorities opened Granville Hotel, Ramsgate, as a convalescent home, under the charge of Col. Watt, Winnipeg. Another similar place, accommodating a thousand Canadians, has been placed at Woodcote Park, Epsom, under the care of English authorities.

Canadian convalescents have also found numerous small establishments ranging from twenty to sixty beds, mostly in the Shorncliffe area.

DEARTH OF DOCTORS

THE problem of the medical student and the need for more doctors continue to engage the anxious attention of all those who have the future welfare of the country at heart.

The medical side of the War Office, so ably presided over by Sir Alfred Keogh, has felt the dearth already. In a recent communication to the Convener of the Scottish War Emergency Committee, the Director-General announced that to outfit the new armies and to supply reinforcements for six months it was estimated that at least 2,500 more medical men of military age would be required. It has been found necessary to bring medical men from Canada, Australia, and New Zealand.

The hospitals have been in difficulties for some time. Recently the chairman of the British Hospitals Association met Sir Alfred Keogh on the subject. Sir Alfred agreed to extend the arrangements under which the resident staffs of hospitals are granted honorary commissions in the R.A.M.C. to all hospitals connected with medical schools, but could not extend the operation of the scheme to other hospitals. The following are the details:—

1. The scheme is only applicable to hospitals connected with recognized teaching schools (not post-graduate schools).

2. All candidates for commissions must be registered medical practitioners.
 3. They must be physically fit for general service.
 4. They shall be called upon to take general service with the Royal Army Medical Corps after three months' residence, and shall be liable to be called up for service before the expiration of that period, if required, on 48 hours' notice.
 5. So far as practicable, not more than one-third of the number of residents will be called up on 48 hours' notice at one time.
 6. Each candidate shall, on being approved for a temporary honorary commission, receive a grant of £20 as an allowance for the purchase of uniform. This is part of the grant of £30 issuable on taking general service.
 7. No undertaking can be entered into that any residents called up for service will be replaced by the War Office.
 8. Applications for temporary commissions should be made to the War Office by the hospital authorities concerned, who will vouch for the candidates whose names they submit.
 9. The authorities of any hospital who wish to avail themselves of this scheme should inform the War Office of the number of beds maintained in the institution, and the number of residents employed.
- The effect of this scheme will be that hospitals will to some extent be secured against losing resident officers, and young medical men going to the front will have some special training before they go.—*Ex.*

Obituary

DEATH OF DR. WAYNE SMITH

IN mid-November, after a week's illness, of apoplexy, Dr. Wayne Smith died. This sad news came as a shock to all his friends; and as a surprise, because he was only thirty-eight. Stricken on Sunday—the Saturday previous, after a strenuous week, he attended an intercollegiate football game at Ann Arbor, enjoying the same with his usual zest.

The deceased was educated in the public schools of Salt Lake City, where his aged father, a medical veteran of the Civil War, still lives with a remaining son. Dr. Smith received his medical education in St. Louis, at Washington University Medical College. Upon graduation he became registrar of the college, and subsequently superintendent of the University Hospital, which position he filled with faithfulness and acceptance for several years.

He was then called to take charge of the City Hospital, St. Louis, where for two years he also gave splendid service. Two years ago he was invited to come to Detroit to take charge of Harper Hospital, the oldest and largest hospital in Michigan. Here again Dr. Smith made an enviable record. He worked very hard in this berth, creating order out of chaos.

Dr. Smith won many friends through his fine generous nature and kindliness. Along with his charitable disposition he combined good executive and business ability, as his financial records both in St. Louis and Detroit show.

Dr. Smith was deputed to make a special study of American hospitals, and his findings are incorporated in the new Barnes Hospital, St. Louis. He was an active member of the American Hospital Association; and also an honorary member of the British Hospitals Association. This journal had the honor of having Dr. Smith as one of its co-editors.

Dr. Smith leaves a wife and three young sons, who greatly mourn his loss. To them the world extends its warmest sympathies.

DEATH OF DR. E. L. TRUDEAU

THE name of Dr. Edward Livingston Trudeau has for many years been associated with Saranac Lake, N.Y., where, years ago, he established the Adirondack Sanitarium. The profession throughout Canada regretted extremely to learn that Dr. Trudeau passed away at Saranac Lake on November 15th, at the age of sixty-seven years. Dr. Trudeau was, unfortunately, himself a victim of tuberculosis, having put up a splendid fight against this terrible disease for some years past. The late Dr. Trudeau was practically the originator of the fresh air treatment for tuberculosis, and conducted his institution with a marked degree of success. The doctor suffered from an attack of pneumonia about three months ago, and, though he rallied for a time, his strength had recently rapidly failed. The doctor was himself the son of a doctor, and graduated from the College of Physicians and Surgeons in New York City, beginning practice in New York, though ill-health compelled him to go to the Adirondacks in 1872, where he has lived ever since. He was formerly president of the National Association for the Study and Prevention of Tuberculosis.

Book Reviews

A Nurse's Handbook of Obstetrics. By JOSEPH BROWN COOKE, M.D. Seventh edition. Revised by Carolyn Gray, R.N., Superintendent of New York City Hospital, and Mary Baker, R.N., late Superintendent of St. Luke's Hospital, Jacksonville, Fla. Philadelphia and London: J. B. Lippincott Co. 1915.

A new edition of a good book is always welcome, and those of us who were "brought up on Cooke's obstetrics" will be glad to see the work continue in popularity and usefulness. It is made on excellent paper, so as to show off the fine illustrations. It contains everything the nurse needs to know on this all-important subject, especially dwelling on the fact that the good obstetrical nurse is a valuable aid in preventive medicine.

Nursing in Diseases of the Eye, Ear, Nose and Throat. By the Committee on Nurses of the Manhattan Eye, Ear and Throat Hospital. New York City. Second edition, thoroughly revised. 12mo. volume of 291 pages, illustrated. Philadelphia and London: W. B. Saunders Company, 1915. Cloth, \$1.50 net.

This work has been taken up by a committee of competent people, in such a way that no part of the ground is left uncovered. In eyework especially there is such a nicety of detail that much more of the patient's care is taken out of the hands of internes and nurses, and is performed by the attending, than in any other branch of hospital work. But with a book of this sort, well illustrated, concise and complete, those details could soon be mastered by a pupil which would facilitate ward work safely, and leave the attending more time. This work discusses all treatments, operations and emergencies in the care of the ear and eye. It shows the nurse the important details in the feeding of children among whom her work will largely lie, since much of the eye and ear work results from the exanthemata

to which the young are most prone. The book is well balanced, being written in part by nurses, who do nothing but teach the practical points in the care of eye and ear patients. Whatever slight points of difference there may be between these and your methods is simply owing to the fact that the staff of writers are entirely at one accord since they all belong to Manhattan Eye, Ear and Throat Hospital. The illustrations make a special appeal, being actually photographed, not drawn from the imagination.

Occupation Therapy for Nurses. By WILLIAM R. DUNTON, Jr., M.D., Assistant Physician at Sheppard and Enoch Pratt Hospitals, Towson, Md.; Instructor in Psychiatry, Johns Hopkins University. 12mo. of 240 pages; 43 illustrations. W. B. Saunders Company, 1915: Philadelphia and London. Cloth, \$1.50 net.

Many nurses have no experience whatever with mental cases until after graduation, when in the course of their varied private work they are sometimes called on to nurse an insane patient, through obligation to the physician or family, or because they consider themselves equal to it, after their arduous general training. Here is just the book to help them. Apart from cleanliness, sleep and prevention of violence to himself or others, the patient has only one claim on the nurse, and that is to be kept occupied. This book is a guide to the choice of occupation and how to conduct each. The author gives much credit to the various nurses who conducted investigations along these lines, teaching their findings to other nurses, who facilitated the spread of this knowledge greatly. The book will be of great use in Canada after the return of the wounded soldiers, who in many cases suffer most from shock, since these occupations are a most soothing sedative. The materials are inexpensive, and the finished products are designed to be useful and saleable, as well as ornamental. The old-fashioned duties of the Colonial housewife, spinning, carding, sewing rags and making hooked mats on the handsome Navajo or other patterns would be found a useful addition to the industries mentioned.

This book should be adopted as a text-book for nurses in every kind of hospital, since surgical and medical patients, children, blind people, all beg at times for something to do, even private patients being included in this grouping. The data ranges from raffia basketry to making sweet jars; and has been collected from personal associates, by the author, with painstaking care. His work should be received with unanimous approval.

Essentials of Medicine—for students beginning a medical course, for nurses, and for all others interested in the care of the sick. By CHARLES PHILLIPS EMERSON, M.D., late Resident Physician the Johns Hopkins Hospital. Third edition, pp. xii, 401 (1 to 6 missing); 117 figures in text. Philadelphia, 1915: J. B. Lippincott Company.

The scope of this work is indicated by its title. It is a book which will repay careful reading by every nurse, and will be a stimulus to any second or third year student in medicine. Your reviewer recommends it to such readers as well as to the young physician who may have to give a course of lectures to nurses. To him it will be a valuable guide, and will offer many helpful suggestions in planning his work.

The reception given the work is evidenced by the fact that since the first edition appeared in 1908 seven reprintings have been necessary.

J. H. E.

Habits that Handicap. By CHARLES B. TOWNS. Published by the Century Co., New York.

This book is meeting with a ready sale. It professes to be a revelation, a warning, and a way out. The author deals with the menace of opium, alcohol and tobacco. The volume is the more welcome at this time because of the enactment of the Harrison Anti-Narcotic law, the enforcement of which makes it so difficult for habitues to procure these deadly drugs.

While one may not agree with the author's rather strenuous methods of treating morphinists and alcoholics, though endorsed

by such eminent authorities as Cabot and Lambert, he cannot help but admit that Towns has done a great service to humanity by calling with such force the attention of the medical profession and the lay world to the terrible ravages of morphine and alcohol.

Mr. Towns maintains that there is need of adequate specific treatment for the drug user; and calls attention to the relationship between the physician and the drug taker. Three chapters are devoted to alcoholism, and two to tobacco. He discusses the sanitarium treatment and points out certain preventive measures which ought to be enforced.

Character and Temperament. By JOSEPH JASTROW, Professor of Psychology, University of Wisconsin. New York and London: D. Appleton and Company, 1915.

To the scientific student, Dr. Jastrow's new book will be read with much interest and profit. Dr. Jastrow, after alluding to the study of character by various empirical methods, such as phrenology, physiognomy and the like, states that the turning point of the inquiry was the recognition of the nervous system as the embodiment of human traits. Equally pivotal, he says, was the recognition that the nervous system, along with the rest of the organic inheritance, has been continuously subject to and molded by the evolutionary forces of nature. The temperamental represents the inherited phase of qualities; character relates to the issues of environmental stress, and to the available channels of expression under given ranges of incentive under the captions of The Sensibilities; The Emotions and Conduct; The Higher Stages of Psychic Control; Temperament and Individual Differences; Abnormal Tendencies of Mind; The Psychology of Group-Traits; Character and Environment; and the Qualities of Men; Dr. Jastrow discusses his subject.

"Character-reading" should be undertaken in a sober, painstaking, systematic study of the laboratory to determine individual fitness and take the measure of a man, according to our author. Dr. Jastrow confesses to have made generous use

of the results obtained by his fellow-workers—more particularly to Professor MacDougal, author of "Social Psychology"; Graham Wallas, author of "The Great Society," and Professor E. L. Thorndike, author of "The Original Nature of Man."

Dr. Jastrow's volume should appeal to every thoughtful student of biology, psychology and sociology. Medical men will peruse with much profit his opinions of neurasthenia, hysteria and other abnormal mental phenomena.

Peg Along. By GEORGE LINCOLN WALTON, M.D., Consulting Neurologist, Massachusetts General Hospital. Philadelphia and London: J. B. Lippincott Company.

Dr. Walton dedicates his book to Crispin and Crispianus, industrious saints of Soissons, born to the purple. They made shoes for the poor and pegged their lives away without unfavorable comment.

The author was forestalled by the Romans, one of whose recipes for troubles was *Solvitur humbulando*—it is solved by going on.

The writer has spent several delightful hours with *Peg Along*; and believes that those of our readers who have read and profited by *Why Worry* will find the new book even more helpful.

The methods of life of Bacon, Franklin are reviewed. The author points out the value that accrues to the character by replacing our vague resolutions by some definite plan.

Dr. Walton gives some well-timed advice to incipient sufferers from the American disease, neurasthenia—sufferers from fears, phobias, etc. He deals with the questions of work and play, and the necessity of maintaining emotional poise. *Why Worry* has gone through sixteen editions. We predict even a much larger sale for *Peg Along*.

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A Letter

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High Grade Malt Goods

IT will be of interest to the medical profession to know that high grade Malt Foods, guaranteed to be free from cane sugar, glucose, corn syrup, or adulterants of any kind, are being manufactured in Canada by Malt Products Company of Canada, Limited, of 448-449 Confederation Life Building, Toronto. Their advertisement appears on page x of this issue.

One of their products is: *Panomalt Extract*—A delicious syrupy confection of high enzymic value. It possesses neither the heavy mawkish taste, nor the stringiness associated with similar preparations on the market, and it is extremely palatable and easy to take. During its manufacture special care is taken to produce a conversion with a high percentage of Maltose and a correspondingly low quantum of dextrins.

It is of special value as a lactogogue and may be used in its original condition, or be dissolved in warm gruels or warm milk, etc. For this purpose—as a lactogogue—it is superior to, and cheaper than, any of the so-called "Malt Extracts" on the market, which are in reality nothing more nor less than dark-colored beers. It may also be used to replace cane sugar or lactose in infant feeding, but for this purpose Maltalose is recommended in preference.

In Affections Involving Deep-seated Structures Pneumonia, Pleurisy, Etc.

A Uniform degree of Heat may be maintained for 24 hours, or longer, by covering the thorax with



warm and thick—at the same time allow a liberal margin to overlap the area involved.

In this way, the aggravating symptoms may be almost immediately ameliorated; the cutaneous reflexes stimulated, causing *contraction* of the deep-seated and coincidentally *dilation* of the superficial blood-vessels—flushing the peripheral capillaries. Thus the over-worked Heart is relieved from an excessive blood-pressure; congestion and pain also are relieved, and the temperature tends to decline as restoration to normal circulation ensues.



Directions:—Always heat in the original container by placing in hot water.

Needless exposure to the air, impairs its osmotic properties—on which its therapeutic action largely depends.

Physicians should WRITE "Antiphlogistine" to AVOID "substitutes."

"There's Only One Antiphlogistine."

THE DENVER CHEMICAL MFG. CO., MONTREAL

Lifebuoy Soap

As a sanitary precaution physicians, whether in private practice or engaged in the larger sphere of hospital work, should, in these days of "Safety First," remember that to keep the surface of the body in an aseptic condition is a consideration of the utmost importance. This can be accomplished by the use of Lifebuoy Soap. This soap, containing carbolic acid, is cleansing and anti-septic, and the oils incorporated means that the patient's skin is left fresh, cool and sweet. Nothing could be more suitable for the bathing of the patient in convalescing from contagious disease, and is also, in the washing of sheets, towels, blankets, etc., the *sine qua non!*

Hospital Furniture

For almost anything in the line of hospital furniture (outside of the operating theatre or ward), hospital authorities should write the Gendron Manufacturing Co., Toronto. They manufacture a splendid line of goods for institutional use, particularly the lines shown in Catalogue C. One line worthy of notice is a chair equipped with carrying bars for taking patients up and down stairs. Without the bars, which can be instantly detached, this chair makes an ideal one for the library, verandah or smoking-room. Write for Catalogue C.

Re-Nu-All Wood Polish

The attention of hospital superintendents and superintendents of nurses is called to Re-Nu-All, a preparation that is without a peer in an institution for use on woodwork of any kind. It leaves a highly polished surface that does not dull, gives the room a pleasant odor, and does away with dust. Re-Nu-All means less work for the probationer nurse and relieves the superintendent of a lot of worry. Try it and see.

Abbey's Effervescent Salt

The following expressions of opinion as to the efficacy of Abbey's Effervescent Salt are conclusive:

"Abbey's Effervescent Salt is especially useful as an antilithic in uric diathesis. It is particularly effective in the treatment of renal calculi, or kidney troubles generally. As an antacid it corrects the acidity of the stomach, making it a specific in certain forms of dyspepsia and in the treatment of gout and rheumatism. It also acts as a mild alterative, rendering the blood and urine alkaline."

"The most effective and elegant aperient for cleaning the gastro-intestinal tract is Abbey's Effervescent Salt."

A Boon to Institution Laundries

In these days when there is considerable trouble in reference to "help" in large Institutions, any effective labor saving device is more than welcome. One such device, which will make laundry work in a Hospital easy, is

TORO TABLETS

Their use will be found a boon, rendering the work of washing far more effective and easy. The TORO TABLET is disinfectant in character, so that no matter how mixed the articles of clothing may be, or how soiled, they come out spotlessly white. TORO TABLETS will not injure the finest fabric and no scrubbing is necessary. One tablet of TORO and half-a-pound of soap and the work is done. Hospitals supplied in large quantities at low prices.

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It is with perfect frankness, and with the utmost sincerity that, without pretending to cure every case of Epilepsy, we recommend to the medical profession **GÉLINEAU'S DRAGEES**, which have given to their inventor the most complete satisfaction for 30 years and have earned for him the gratitude of numerous sufferers. **GÉLINEAU'S DRAGEES** offer to the practitioner a superior weapon, giving him the possibility of a triumph in ordinary cases, and in all cases the certainty of at least a marked improvement.

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In an institution where it has been found difficult to keep the hardwood flooring polished, on account of lack of sufficient labor, C. & B. Floor Wax should be used. Why? Because, once properly applied, it leaves a polish that remains, and the help need not worry about it for some time. C. & B. Wax is particularly well adapted also for cork linoleum, battleship linoleum, and many composition floorings. It is not only a labor saver, but, for reasons as stated, its use means money saving as well.

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Platt's Chlorides, the Odorless Disinfectant, does all the work a disinfectant is called upon to do—quickly, thoroughly, economically and without objectionable features of any kind.

It is harmless and does not stain articles which it touches, when diluted according to directions. It is used universally, has the endorsement of the medical profession everywhere, and is far superior to the coal tar products on account of being free from any pungent odor which so many of them contain.

Platt's Chlorides not only removes odors, but destroys the cause. It is of big value in the sick room as well as the household.

An attractive booklet, "The Sanitary Home," will gladly be mailed on request, by addressing the manufacturers, Henry B. Platt, 42 Cliff St., N.Y.

The Kiddie-Koop

ON another page of this issue something entirely new and equally novel is brought to the attention of hospital superintendents, doctors and nurses in the Kiddie-Koop, a piece of baby furniture that comprises a bassinett, a crib, a play pen, a caretaker and baby walker, all ingeniously combined in one article, that folds up in one operation of a second's time to a width of seven inches.

In the United States, where the Kiddie-Koop has been on the market less than two years, it has received the hearty and unsolicited endorsement of many doctors, and when adopted by hospitals it has proven a great protection and benefit to the

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CHICLETS

will be found to be a valuable adjunct in the treatment of some digestive disturbances, their use stimulating the secretion of ptyalin.

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children, and a great saver of labor and time on the part of the nurses. The Kiddie-Koop is now made in Canada, and from standpoint of workmanship and materials leaves nothing to be desired. A special offer is being made to hospitals that all superintendents will find worthy of investigation. The manufacturers are Lea-Trimble Mfg. Co., Dominion Bank Building, Toronto.

The Branston Violet Ray High Frequency Generator

THE attention of Hospital Superintendents is called to the advertisement, appearing in this and subsequent issues, of the Chas. A. Branston Co., 359 Yonge Street, Toronto. This firm are Canadian representatives for one of the best Violet Ray High Frequency Generators made. It is entirely unnecessary to tell the medical profession anything in reference to the value of such an instrument in the treatment of certain conditions, all the firm wish to do being to let the profession throughout Canada know that such an instrument can be purchased at a most attractive price, an instrument that is in every way guaranteed and will be found to be one of the most satisfactory procurable. The firm also carry a full line of the celebrated White Cross Vibrators and other electrical specialties.

Hospital Bedsteads

THE attention of hospital authorities is called particularly to the advertisement in this issue of Messrs. Hoskins & Sewell, Ltd., of Birmingham, England, whose Canadian agents are The F. G. Soper Co., Laughton Avenue, Toronto. This firm have for sixty years made a specialty of the manufacture of Hospital Beds, and have succeeded in placing at the disposal of Institutions a bedstead that is almost without a peer. This bed is the result of many years' study of what is most required in a hospital, being manufactured to stand the roughest of wear and tear and at the same time to afford the patient the acme of comfort. Messrs. Hoskins & Sewell manufacture every component part of their bed, not being dependent upon other manufacturers in any way. One of their principal lines is The James Bedstead, which is ideal for open air sanatoria and can be wheeled around by the convalescent patient without the least effort. Catalogue on request.

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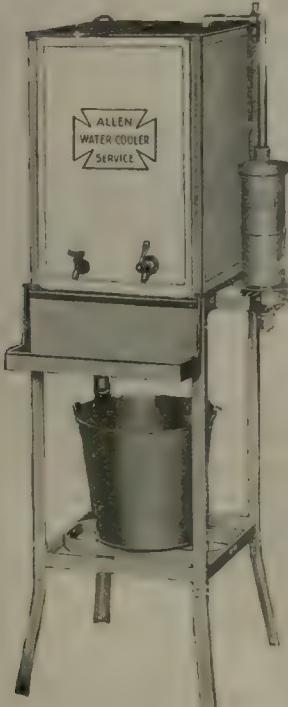
THE PARTICULAR ATTENTION OF
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The Allen Germ-Proof Water Purifier and Cooler

In these days, when the water supplied in many of our cities is not what it ought to be, the Profession and, through it, the Public will welcome such a device.

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for HOSPITAL SINKS, URINALS, BEDPANS, FLOORS, GLASSWARE, ENAMELWARE, MILK BOTTLES, and all KITCHENWARE.

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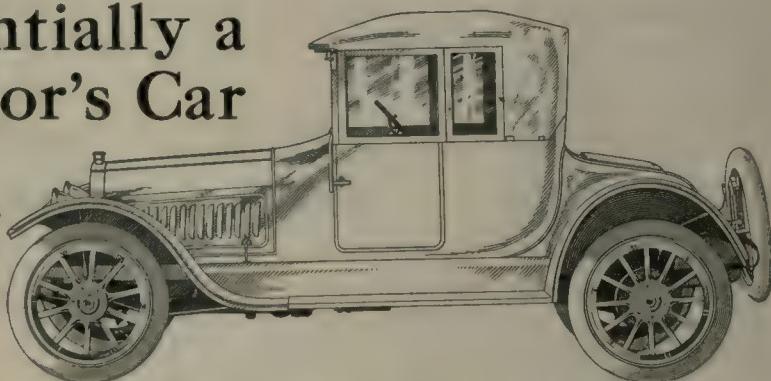
H-O AMMONIA is one of the cheapest and most effective Disinfectants, and Hospitals' Superintendents should give it a trial, as once they do, nothing else will be used.

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has been proven to be the means of preventing small fires from spreading and saving many lives that would otherwise be snuffed out.

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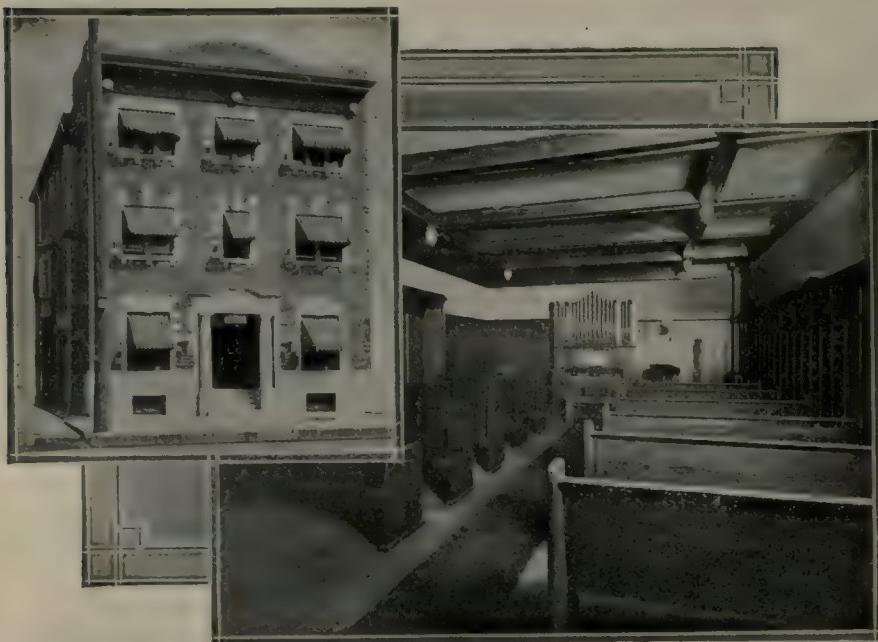
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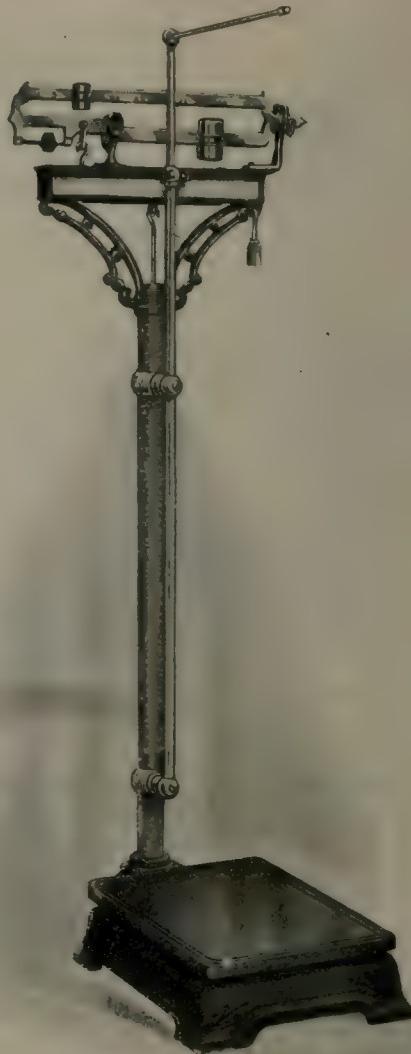
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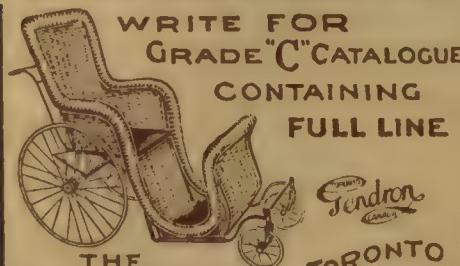
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THE HOSPITAL WORLD

Vol. IX (XX) - Toronto, February, 1916

No. 2

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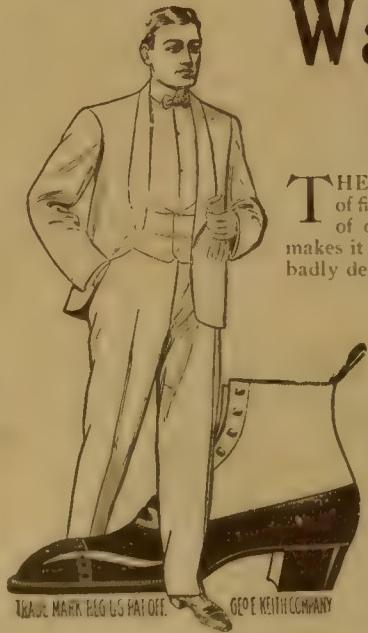
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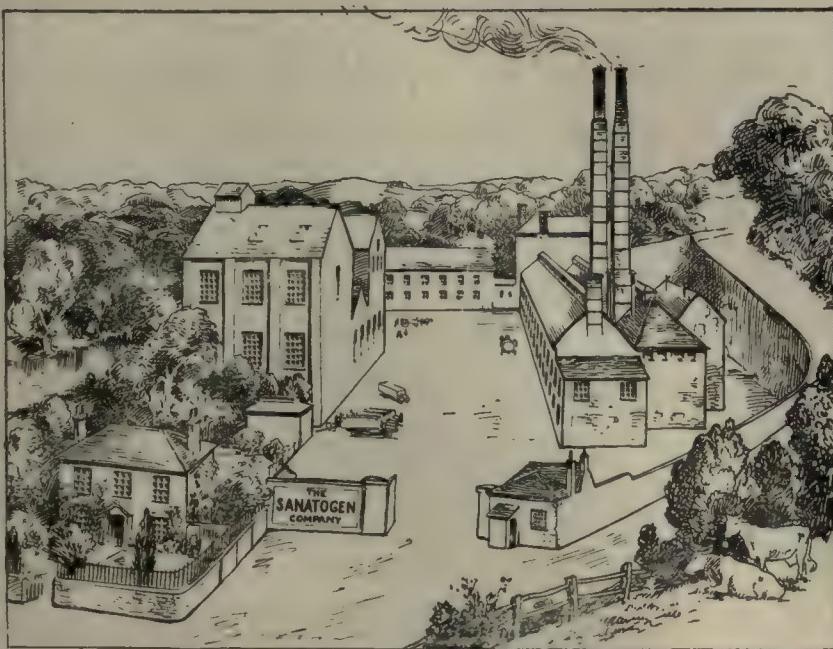
¶ It will be printed for the purpose of helping to run hospitals right. It will be brimful of ideas, suggestions and reports of successful methods. It will not be a medical journal, but it will be the hospital man's business paper.

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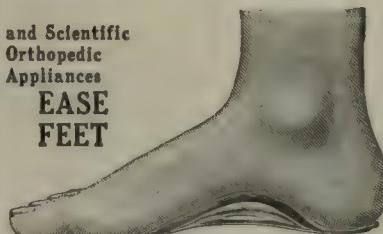
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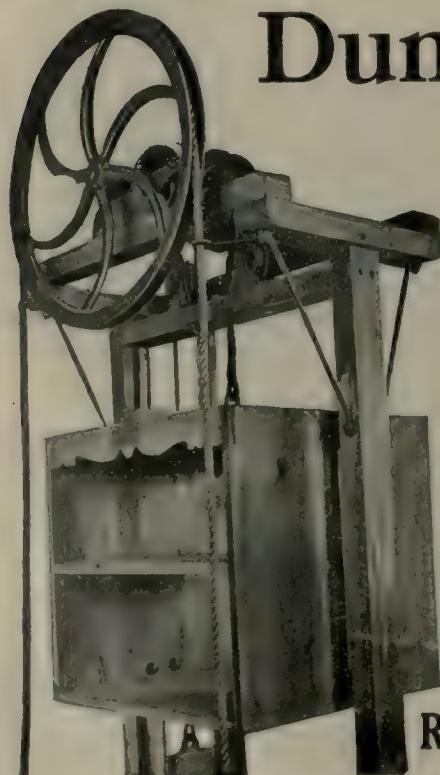
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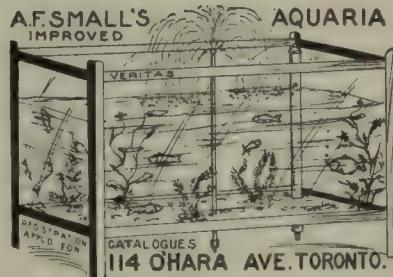
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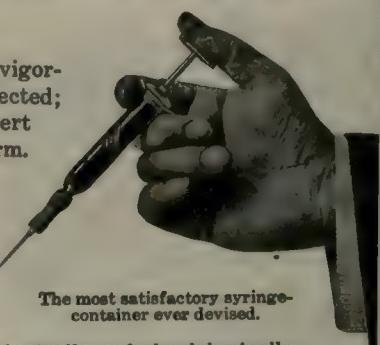
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Editorials

KNOWLEDGE OF VALUES

IT is well for those who are called on to practise hospital economies to know where the money comes from and where it goes to. To know the cost of buildings,

installations of fixtures, equipment, furniture, and supplies of all sorts. Such knowledge makes for economy.

Hospital workers should know something of the meaning of hospital foundations, endowments and of all sources of support, whether governmental, municipal, church, fraternal society, voluntary—separate or combined. They should also know the sources of income earned by the hospital—from patients, of occupying the various classes of wards—private, semi-private or public; from the operating room, the X-ray department, the bath house, the dispensary, and the students, and all other sources of income.

Much stress should be laid on the importance of doctors and nurses knowing the value of all sorts of supplies used daily by them—instruments, rubber goods, gauze, cotton, drugs, food supplies, etc., etc.

RADIUM IN HOSPITAL PRACTICE

THE opening of a radium dispensary last month in New York is an event of too great importance in the healing world to be passed without comment. Sick beyond words with knowledge of cruelties and slaughter we turn with relief to those things which speak of the humanities and of life-saving.

In view of the latest cautiously-worded certainties of radium experts, hope is growing stronger that within a decade cancer and kindred malignant dis-

eases will, in some large measure at least, be brought into subjection and control.

In a very recent pronouncement by Drs. Kelly and Burnham, of Baltimore, than whom no specialists in this department of surgery may be better relied upon, in discussing cancer of the cervix uteri, and vagina, they give utterance to such hopeful conclusions as these:

"Our knowledge of the curative action of radium on cancer is as yet in its infancy; nevertheless, its ultimate possibilities viewed in the light of present experience, seem very great. That it does greatly diminish the percentage of the incurable is already evident and demonstrable. . . .

"We are convinced that radium is of exceedingly great value in the treatment of these cancers. . . .

"We emphasize that the betterment in the improved, but not cured, cases, is so marked that it alone makes radium a great addition to existing methods and would justify its use.

"We believe that every inoperable cancer (of the parts mentioned) provided general metastasis is not present, stands a chance of at least one to four of cure by radium treatment. There is marked reason to believe, not only that a large number of inoperable cases are curable, but that by the joint use of radium and operation the 1 in 4 cure rate of operation in operable cases may be raised to 3 in 4 or better."

Since these experts assert that patients must be five years cured in order to be sure of the perman-

ency of results, it is easy to understand the need of caution in pronouncement.

A rather interesting point brought out is, that all conditions being similar, widely different results are often obtained in cases subject to the same radiation,—that in one the cancer disappears promptly, while in another it is not affected at all—suggesting, it is inferred, the degree of resistance in the patient.

This finding supports the rapidly-advancing belief in what may be termed therapeutic individualism, the modification or intensifying of diseased conditions by some determining individual factor, which must be located and taken into account.

In treatment by radium, patients are rarely in the hospital much beyond the time of treatment since, as a rule, no disagreeable symptoms follow. They are able to return to their homes; coming back at prescribed intervals for examination, and, if needed, further radiation. In this fact lies one of the great values of a radium dispensary.

The object of the New York institution is not only to fight malignant disease, but to carry on research work with the X-ray. It will be conducted along the lines of the radium institute of London. American philanthropists, by their backing, have made this great boon possible by providing over \$150,000 worth of radium as a beginning.

ARMY MEDICAL SERVICE

THAT there is at present no dearth of volunteers in the Canadian army medical service for the front is made evident by the regulations regarding the same recently adopted by the authorities at Ottawa. And by inference it may be assumed that there is no need—no present need, at least—of men of mid-life and acquired professional standing sacrificing large practices in order to help out in the war hospital service.

In fact, such a fortunate condition is distinctly stated to be the case by the Department. In reply to offers of service received from medical men of this class in various parts of the country, the Department is able to state that thus far it has not been found necessary to consider offers of men beyond the imposed age limit (forty-five), in view of the large waiting-list of young men: that medical volunteers, whatever may be their age, standing or qualifications, must be prepared to take any rank, go to any part of the war zone, and do any kind of work; that his status and location will be allotted him by the Canadian heads of military service in London on his arrival there; and that he must undertake to serve for the entire period of the war.

That the large number of applicants offering for service places the authorities in position to make such stipulations is a cause for congratulation and an honor to the profession in Canada. Naturally, however, the result has been the withdrawal of not a few

applications of men who were under the impression, apparently unwarranted, that as experienced practitioners, specialists and experts in one or other branches of their profession, they could render service that would not only be of value but in demand.

The terms of service as set forth to each medical volunteer are doubtless necessary, and therefore desirable, from the military and departmental standpoint. They bear the stamp of system and discipline peculiar to military life. But the medical volunteer of specialist standing says: "Here I am. This one phase of service I can undertake best; and I am ready to place all of the skill and experience that study and the years have given me in this line at the service of the Empire, if needed. But I am not willing to leave my practice for an indefinite mission, knowing neither the place nor character of the work I may be called upon to do."

That the detailed appointments of place and rank of service are made by the Canadian medical heads already established in England does not appeal to this class of volunteers. They do not go over as wire-pullers, eager for high ranking and positions of authority; nor yet to work in lines involving strenuous physical service best rendered by young doctors and recent graduates.

They desire only the assurance that there is a definite place and work awaiting them where their skill and expertness, acquired by experience and study, will be of value in the Army service.

That there is evidently no such present need, and that the Canadian army medical service has all and more of skilled volunteer service than it can utilize, must be a matter of just pride to the Canadian profession. In the meantime many of our Canadian medical men of expert standing enjoy the comfortable sense that they have made their readiness known and that they stand still prepared for definite service if definite service be asked of them.

Original Contributions

WHAT SHOULD DIETITIANS AND DIETITIAN-HOUSEKEEPERS BE TAUGHT AND HOW TRAINED?

BY LAURA E. COLEMAN, BUFFALO HOMEOPATHIC HOSPITAL.

The demand of the present Hospital world is for standardization—standard nomenclature, standard records, standard accounting, standard equipment, standard education for Nurses, standard ideals. Is not this great body of Hospital Superintendents and Trustees assembled for but one purpose—the standardization of hospitals in every department, by interchange of thought and plans of work, each giving to the other the best of experience and result in their special field? Why should there not, therefore, be a standard for Hospital Dietitians?

Within the past twenty years a great change has come over the educational side of hospital work. The length of a nurse's probation has been increased from one or two months to three or six months; her time of training from two to three and, in some schools, even to four years. The standard has been raised slowly but persistently. The nurse-in-training *must* have had one year at High School, or, better still, she must have graduated from High School. Trained teachers have, in all schools that can afford them, replaced the old time graduate-nurse teacher, who taught what she knew and taught it well, too, but who often had no special training in the proper method of imparting that knowledge to others.

Trained Dietitians are filling the place made for them by the recent attitude taken by physicians toward food and its effect upon the human body. Fifteen years ago little was heard, even in our best managed hospitals, about food values, calories, carbohydrates, etc., and a good steward, with a chef and his staff,

supplemented by the work of the nurses-in-training on the ward floors, was considered sufficient. An occasional Staff Physician gave special attention to his patient's food, but with nothing of the definiteness of the present day, when even the smallest hospital has to meet this demand for every variety of special diet.

All nurses-in-training had, even twenty years ago, cooking lessons in which beef juice, custards, jellies, toasts, liquid diets and gruels were the predominating features.

To-day, a pupil nurse is taught, in a course of from ten weeks to three months, the preparation, constituents and caloric value of foods for patients and hospital household, with the proper way to measure and serve them. Before she leaves the Dietary Department, she learns, or should learn, to prepare a well-balanced diet for any patient—salt-free, diabetic, fat-free, etc., and if the Dietitian is the woman for the position, the young nurse will also learn the cost and quality of foods, relation of supply and demand, and, not least of all, when entrusted to assist with the checking of this, the heaviest expense-sheet of a hospital, she will learn how to so care for and dispense these foods, that each shall reach its proper destination suitably prepared, and so palatable that there will be little waste because they "did not like the food," and absolutely no waste from carelessness in dispensing.

Intelligent nurses-in-training require intelligent, well-trained teachers; and this, for one thing, the Dietitian must be.

In a 30 to 60 bed hospital the question of "How and what shall patients, officers, internes, nurses, and, last, but surely not least, our faithful domestics, be fed?" is just as important as the same question in a hospital of 1,000 beds. The same problems of feeding the patients in small hospitals present themselves, as in large ones. One patient taken into any hospital deserving the name is as worthy of careful feeding as are one hundred such patients.

Many 30 to 40 bed hospitals do not have a trained Dietitian, but someone must do the work intelligently, and it is upon the already overworked Superintendent of the small institution that this grave responsibility rests. Armed with her long, or

short, training in hospital dietetics, she grapples with the question, and grapples intelligently in most cases—for what she has forgotten, or perhaps never knew, of calories and food values, she overcomes by study and preparation—her mind being trained to meet just such extra demands. Then comes the luxury of a Dietitian-Housekeeper, for in the smaller hospitals, usually because of economy in salaries, the positions are combined. Besides there would be insufficient work in a small hospital in either department to keep a woman, mentally active, contented with one position alone.

With a trained mind, such as a Dietitian should have, and with the executive ability a hospital Dietitian must have, she can readily do any hospital housekeeping by an additional short course in laundry management; for this, of course, is the crucial point in hospital housekeeping. With the splendid training she will have had in asepsis and absolute cleanliness, in her general Domestic Science course as Dietitian, and with some knowledge of laundry work—counting that she has ability to manage people—the housekeeping will be very easy, so on that side of the work I shall touch but lightly.

There is but one Dietitian for any hospital, large or small, and that is the Trained Dietitian.

What shall she be taught? She shall be taught dietetics in all its branches—foods, quantity, quality, cost, value to patient, scientific distribution under a physician's orders; everything, in fact, that affects the well-being of a patient or household in the matter of proper feeding. This course of training should not be less than two years, and, if any academic work is attached, it should, as in several colleges and schools of domestic science, reach to four years. Surely two years, however, is little enough for anyone engaging in this, so important a branch of hospital work, to give to her training. The physician gives five to eight years to his training; the trained nurse gives three years of arduous, continuous labor to her work, and why should the hospital Dietitian, who can undo all the good work of the physician, by badly prepared foods, give so much less, as is sometimes the case?

In a letter to me regarding this paper, the writer stated that one superintendent had said that the Dietitians sent him by a domestic science school were so very young and impractical that, what with a training-school of young women, it was but one more responsibility, and hereafter he would employ only mature, practical Dietitians.

I sympathize sincerely with him, as in the first hospital of which I had charge, a small hospital of 30 beds, I came to the same conclusion. From two of the best training schools I tried Dietitians, who, of course, took the position of Dietitian-Housekeeper. They could talk most intelligently and scientifically on food-values; could arrange and display all kinds of desserts and salads, knew to a degree the caloric value of foods theoretically, but lacked judgment—judgment as to quantity for 30 patients, nurses and hospital household—judgment as to care of and ordering of food supplies. A vegetable garden was to them an untried field. They counted vegetables only in bushels, or baskets, or bunches, as they had seen them in the domestic science schools. They were excellent theorists, but their extreme youth and total lack of practical experience was very discouraging.

I then decided that the domestic science training schools were to blame entirely for turning out and recommending to hospitals needing Dietitians an unfinished product, to complete her training at the expense of the hospital; but I now believe that a word of our needs to those schools would have given them an opportunity to help solve the problem.

Perhaps the lack of hospital ethics which they displayed was not the least trying part of their failure to fill the situation. They had been taught no sense of responsibility to time. Fifteen minutes earlier or fifteen minutes later carried to them no grave responsibility.

Like the superintendent of whom I have spoken, I then decided that a trained Dietitian was not for small institutions, and engaged a practical Dietitian-Housekeeper of mature years and judgment—one who could utilize the asparagus and other vegetables from our own garden and could preserve or can fruits purchased in quantities, when such fruits were seasonable; in

fact, one who, except for the fact that she knew nothing of calories and food-values, gave our patients well-cooked porridge, delectable gruels, perfectly-broiled steaks, and such vegetables it is a pleasure to remember them. She was also an ideal house-keeper. The special diets, however, had to be arranged and planned by the Superintendent of Nurses. The nurses-in-training took their practical work in housekeeping with the Dietitian-Housekeeper, and were sent to Miss Fannie Farmer for their cooking lessons and special dietary work.

For a small hospital this did solve the problem, but from broader experience I have quite changed my mind. I find that to administer a hospital of 150 beds, or five times the original unit, there must be a Housekeeper *and* a Dietitian, and that dietitian must be trained and well-trained.

Where should she be trained? I believe hospital Dietitians should be trained in some one of the many perfectly equipped Domestic Science schools or Colleges, for not less than two years, and that for at least six months this training should be supplemented by a practical course in hospital dietetics in some one of the many good hospitals of this country. For at least one month of this time, it would be well if she could be given entire charge of the department.

The demand always creates the supply. If the members of this Association would appeal to the Domestic Science schools of the country for this extension course for would-be hospital Dietitians, assuring them of co-operation in affording their qualified pupils an opportunity for this course of practical work, I believe they would be only too glad to give it.

As in our training school for nurses we select, from a class of fifteen or twenty, two or three, or maybe but one, who will make a good Executive, and add her to our Junior Executive force, for practical experience in hospital work, so, I believe, these Domestic Science schools might select the three or four pupils from each class who show signs of executive ability—mature pupils with tactful, well-balanced minds, wishing to qualify for hospital work, and recommend them for this Hospital Extension Course. If this were done, I am convinced

that hospitals, both large and small, would fill dietetic vacancies with less waste of energy and efficiency.

In the hospital of which I have charge at present, we have tried this plan. Our present Dietitian was trained for two years in a Domestic Science school which already sends out its pupils to one of the large hospitals for hospital experience. In addition to this she remained one year as Junior Dietitian in the hospital, giving the practical course. She controls her kitchen force, selects and cares for the food supplies, is responsible for all foods, teaches the nurses Theory, and two, who are with her continuously, have their experience in applied dietetics. This she does in a business-like manner. Of course, in a hospital of 150 beds, she does not do the housekeeping, but were the same woman in a hospital of 50 beds, she would manage the entire domestic force, administer the housekeeping and, with a short course in the one trying spot in housekeeping—the laundry—would do it easily. It does not seem to me that this would be impracticable if the Domestic Science schools would recommend for this Extension Course only those showing the proper qualifications for hospital work.

I have written several of the Domestic Science schools regarding a special Hospital Course in Dietetics, and find that some of them already have a limited course, and that the schools themselves are giving thought to this subject. I quote from one school who says they give a Normal Course with Dietetics, and a Housekeeping Course with Dietetics. "But," says the Director of the Domestic Science School, "I think a combination of both courses would be best for a hospital Dietitian." "And," she continues, "I think graduates of such courses as ours are not prepared for independent dietetic work in hospitals because of their ignorance of hospital discipline and conditions. This is probably at the back of the friction we so frequently hear of between hospital superintendents and dietitians. Probably the best preparation for a dietitian would be hospital training and experience followed by a good Normal or Housekeeper's Course in Home Economics. Failing this, the next best thing is a good course in Home Economics followed by pupil dietitian or apprentice work in good hospitals.

A satisfactory course would, I think, be easy of arrangement.

"It is my experience that as yet we have no standards for hospital Dietitians. Each hospital is a law unto itself with regard to the work a Dietitian is expected to do. It may range from all the buying and housekeeping for the hospital to a mere matter of preparing and sending up private patients' trays. If your Hospital Association will discuss this and point out the wisdom of hospitals furnishing training schools with a clear outline of the duties demanded, it will help the cause of Dietitian-training materially."

Another Director of Dietetics says: "Occasionally one of our regular seniors wants to go into hospital work, and we invariably advise such a student to take training as a student dietitian. We feel very strongly that we cannot give, under collegiate conditions, anything which approximates the broader training for hospital work."

Teachers' College, Columbia University, says, in reply to the question as to feasibility of a practical Hospital Course for Hospital Dietitians: "Such a course of training in a hospital is not only practical, but highly desirable, and with suitable co-operation from the hospitals could easily be arranged."

It would seem to me, therefore, from my own personal experience, and from the data I have collected, that qualified hospitals have but to offer this Extension Course to the Domestic Science schools, for their would-be hospital Dietitians, and the problem is solved.

Selected Article

HOSPITAL CANCER STATISTICS

Dr. Joseph C. Bloodgood and the Johns Hopkins Hospital are to be congratulated on the collation of their statistics on cancer. Such work does an untold amount of good, and other hospitals should follow the Hopkins lead.

This special effort to ascertain the results of some 5,000 cases of external cancer was made possible through the expenditure of some \$2,000 generously contributed by a few friends and patients. The work was performed by a corps of medical students and two stenographers.

Letters were written to the ex-patients and their doctors, and every effort made to trace lost cases. A certain percentage of the cases were not found.

Bloodgood's report covering twenty-five years shows a record of 1,300 cases of breast tumors. His study shows that if any woman over twenty-five submits to an operation within a few days after the lump in her breast is first noticed her chances are about fifty per cent. that the lump will be benign, and that a cure can be accomplished by the removal of the lump only; and that, in the majority of cases, the breast itself will not have to be sacrificed.

If upon the exploration of this lump it should prove to be malignant, the woman's chances are one out of four that the type of cancer is the least malignant, and the immediate radical operation yields one hundred per cent. of cures. Dr. Bloodgood holds, at the very worst, the probability is that there would be 85 per cent. of cures.

In 1908 27.5 per cent. of cases of cancer of the breast were inoperable; in 1913, 18 per cent.; which shows that the laity are being educated to seek relief earlier in the disease.

In 1908 9 per cent. of the cases were cases of recurrence; in 1913, 6 per cent. In 1908 the percentage of cases cured at the

end of five years was 35 per cent.; in 1913 the percentage had risen to 42 per cent. This result, Dr. Bloodgood maintains, is due to earlier intervention on educated women, not on better surgery.

In 35 cases of adeno-carcinoma there were 76 per cent. of cures five years after operation. In 15 early cases the disease was completely eradicated. Of the late cases -20 in number--there were 64 per cent. of cures.

Of 92 cases of carcinoma of the breast, 36 per cent. were cured. Of those taken early 85 per cent. were cured; and of late cases, 33 per cent.

In the least malignant form of cancer of the breast the Johns Hopkins' records show that incomplete operations in the early stage reduce the probabilities of a cure from 100 to 9 per cent.

A study of results in cancer of the lip shows that the cases of benign tumors presenting themselves in 1908 represented 4 per cent. of the cases; in 1913 the percentage had increased to 18 per cent.; while the number of inoperable cases presenting themselves decreased from 18 per cent. in 1900 to 5 per cent. in 1913; which speaks volumes for the educational propaganda carried on during the interim between these two years.

Another table presented by Dr. Bloodgood showed that any treatment of the lip lesion previous to that given at Johns Hopkins—which was not effectual—reduced the chances of cure from a later proper operation from 75 to 33 per cent.

In only 11 instances—7 per cent. of the cases—had patients sought advice for the little lesion on the lower lip at the most favorable period, that is, within the first three months of its existence—simple operation during which period effects 100 per cent. of cures.

In cancer of the tongue, benign cases, during the period of 25 years referred to, increased from 8 to 30 per cent.; inoperable cases decreased from 18 to 10 per cent. The number of post-operative deaths remained the same—22 per cent. Cures have increased from 21 to 50 per cent.

Society Proceedings

THE BRITISH HOSPITALS ASSOCIATION

The annual meeting of the British Hospitals Association was held at the Westminster Hospital, London, on Thursday, November 18, 1915. Mr. H. Wade Deacon, Chairman of the Royal Infirmary, Liverpool, presided. There was a good attendance of members, and amongst those present were the Rev. G. B. Cronshaw, Chairman of the Radcliffe Infirmary, Oxford; Mr. S. M. Quennell, Westminster Hospital; Mr. T. Maddock, Wellington Hospital; Mr. W. J. Morton, Mount Vernon Hospital; Mr. C. S. Risbee, Northampton Hospital; Mr. A. H. Leaney, Birmingham General Hospital; Mr. D. S. Paterson, Samaritan Free Hospital; Mr. R. J. Bland, Royal London Ophthalmic Hospital; Mr. W. H. Harper, Wolverhampton Hospital; Mr. J. Courtney Buchanan, Metropolitan Hospital; Mr. H. J. Toulmin, St. Albans Hospital; Mr. Howgrave Graham, Hospital for Epilepsy; Mr. R. A. Owthwaite, Hon. Treasurer; and Mr. Conrad W. Thies, Hon. Secretary.

The Chairman, in opening the proceedings, said he was quite sure that the members would understand why it had not been practicable to hold the usual annual conference during the present year. It was proposed at this meeting to transact the ordinary business, and he now moved that the vice-presidents, council, and officers be re-appointed, with the exception of Mr. W. G. Carnt, who, they much regretted, had been obliged to withdraw from active work on account of ill-health. In his place it is proposed to elect Mr. F. G. Hazell, Mr. Carnt's successor at the Royal Infirmary, Manchester. Mr. J. Courtney Buchanan has kindly consented to act as joint honorary secretary with Mr. Thies. He would ask the members to leave the appointment of president for the ensuing year to the council, in order that they may be able to elect a gentleman from the city where the next conference is to be held.

The Rev. G. B. Cronshaw seconded the Chairman's proposals, which were unanimously agreed to.

The Chairman said that, before asking Mr. Sydney Smith to read his paper, he wished to offer a few general remarks in reference to the work of the Association during the past twelve months. Although they had not been able to hold a conference, the Council had been active in many ways. Firstly, there was the question of the treatment of wounded and sick sailors and soldiers. At the beginning of the war many of the voluntary hospitals were undecided as to whether they should ask for payment in respect of these patients. In response to many inquiries the Council issued a circular letter on the subject, and received a large number of replies from hospitals in all parts of the kingdom. After some correspondence with the War Office, a letter was sent to the hospitals recommending those institutions who had not already made arrangements for payment, but who desired payment for these patients, to make application to the local military authorities, as was suggested by the War Office; and this advice was generally acted upon.

The question of freedom from the duty on spirits for use in hospitals was also considered, but as this subject was being dealt with by the British Medical Association and the Pharmaceutical Society it was decided to leave this matter in their hands. Although at present no relief from this duty has been obtained, it is anticipated from a statement made by the Chancellor of the Exchequer that provision would ultimately be made to relieve the hospitals from that charge. In response to requests from several hospitals, the question of "badges" for hospital employees was considered. The War Office, however, declined to recognize such badges. The present position of hospital employees under Lord Derby's scheme is that all of military age should offer themselves for service, and after they had been attested it would remain for the hospital committees to make application to the local tribunals for exemption for those of their employees who were considered indispensable for maintaining the work of the hospitals.

It would be remembered that a circular letter had also been issued giving the result of an interview with Sir Alfred Keogh,

Director-General of the Army Medical Service, in reference to the shortage of resident medical officers in the voluntary hospitals. Sir Alfred Keogh pointed out that the medical needs of the Army and Navy must necessarily be paramount at the present time, but he agreed to extend a scheme which had been arranged with certain large general hospitals to all hospitals connected with recognized teaching schools. All the hospitals found it difficult to obtain the services of qualified medical men for resident posts. In Liverpool and in many other places qualified medical women were employed wherever their services were available. Under these circumstances the voluntary hospitals have no remedy, but must do the best they can, and wherever practicable should secure the services of general practitioners to carry on the work. It is not possible under existing conditions to make any definite statement as to the next annual conference. If, however, the war should end, he hoped they may be able to hold a conference in 1916. And he had no doubt that in that case Liverpool would renew the invitation which they gave to the Association last year. He would suggest that this matter be left in the hands of the Council.

In concluding these remarks he wished to refer to the great loss the Council had sustained during the present year through the death of two of its members—Mr. Alexander Hayes and Mr. Howard Collins, both of whom had taken a very active part in its work and had rendered valuable service to the Association.

HOSPITAL ANNUAL MEETINGS

Reports of a satisfactory year of work have been submitted at the annual meetings of many hospitals in the Province. At the Owen Sound General and Marine Hospital the number of patients treated was 474, and 47 births and 26 deaths occurred; this hospital contains 57 beds. The Smith's Falls Public Hospital, during its sixth year of activity, received 501 patients; 51 births and 17 deaths took place; the net deficit amounted to \$1,352. Five hundred and thirty admissions were made at the Royal Victoria Hospital, Barrie, and 18 deaths and 95 births

were recorded; the total number of days of treatment was 12,949, and the financial statement showed a deficit amounting to \$107.34. At the Bowmanville Hospital 207 patients were admitted; 16 births and 13 deaths occurred. The Galt Hospital admitted 576 patients during the year; the births numbered 64 and the deaths 48; 11,291 days of treatment were given; the financial statement showed a balance on the right side amounting to over \$500. Two hundred and eighty-eight admissions were made and 33 births occurred at the Victoria Hospital, Renfrew. At the Cornwall General Hospital 757 patients received treatment, as compared with 638 during the previous twelve months. The days of treatment numbered 11,735 as compared with 9,853 in 1914. The number of patients who received treatment in the Wingham General Hospital was 135, the days of treatment being 2,003; these figures are slightly in excess of those for the previous year. The report of the year's activity at the Ross Memorial Hospital, Lindsay, shows that 449 patients were treated, including 58 soldiers; 195 operations were performed; there were 22 births and 25 deaths, the total number of days of treatment was 6,382, the daily cost of maintenance per patient being \$1.85. At the General and Marine Hospital, Collingwood, treatment was given to 400 patients; 28 births and 28 deaths occurred; the daily cost of maintenance was 98 cents per patient. One hundred and eighty-nine patients were admitted to the Cobourg Hospital during the past year, 65 operations were performed, and 3,197 days' treatment were given. The hospital work has been much facilitated by the convenient new building with its equipment.

War Hospitals

LATEST CANADIAN HOSPITAL WAS OPENED AT RAMSGATE

Apart from the heroism of the Canadian troops, nothing has evoked greater admiration in connection with Canadian effort since the outbreak of the war than the way in which the Dominion has followed her sons with hospitals and medical service. In France and England it is realized that Canada is doing her part with noble enthusiasm in caring for the sick and wounded.

As soon as the need for a new hospital or convalescent home arises it is met, and if the people of Canada could only see some of the institutions which have been brought into existence by their generous impulse, combined with the efficiency of the Canadian Army Medical Corps and the enthusiasm of the Canadian Red Cross, they would appreciate how great is the service to which they are contributing. It is difficult perhaps, when three thousand and more miles away from the scene of operations, to have a right appreciation of this work, but its greatness has appealed to the British public.

LOCATED AT RAMSGATE.

Another hospital has been opened at Ramsgate, which promises to be one of the most important of Canadian medical institutions in England. "Doctor Ramsgate," as *Punch* once called this popular resort on the Kentish coast, two hours distant from London, has, like other watering-places, suffered in consequence of the war, but although the Kaiser has robbed it of its "season," even the German war lord cannot rob Ramsgate of its natural charms. The latest Canadian hospital finds itself in a beauty spot of Kent.

It is known as the "Granville Canadian Special Hospital." Until recently the building was a large modern hotel. It has a magnificent situation on one of the high cliff promenades, with a splendid outlook upon the sea, and with an enlivening view

of the shipping, which continues as though Von Tirpitz and his submarines never had existed.

Canadians are credited with a keen eye to essentials. The selection of this building for the special purpose for which it was intended was certainly an excellent choice. It affords accommodation for six hundred patients, and in addition to the excellence of its situation, the internal design of the building, with its suites of rooms, electrical installation, and bathing facilities, renders it singularly appropriate for a hospital. Incidentally the greater part of the hotel furniture has been suffered to remain, which gives the interior a very cosy appearance.

As its title indicates, the hospital will be used for special cases. One of the features of the equipment is the electrical apparatus. Care has been taken that the patient shall have all that science and skill can command, and for that purpose the most modern appliances have been installed. The hospital is also provided with a complete Turkish bath, as well as with a large salt-water plunge bath. The bathing facilities, indeed, within the building are excellent.

On entering the building the visitor finds himself in a spacious hall, where a patient may receive his friends. On the same floor is the dining hall, where a large grate with its ornate mantel attracts attention. "Pile on the logs; make the fire great," is an appropriate sentence in the scheme of decoration, and it may be taken for granted that the "boys" will see that they have sufficient heat to counteract the penetrating influence of winter, for, although the thermometer rarely goes to zero, the occasional raw climate of an English winter is not without severity. But the Canadian medical staff, who have superintended the equipment of the building, which is to be used exclusively for Canadian cases, have seen that the heating is effective.

There are four storeys above the ground, along each of which is a corridor with which the wards communicate, and at the end of each corridor is a sister's office. The soldiers obviously enjoy the quietude of the cozy rooms, where beds have been arranged and from many of which beautiful sea views are to be obtained.

A wide staircase leads from the ground floor to the top storey of the hospital, but there is also an elaborate elevator for the use of patients. The building having been previously used as a first-class hotel, it may be imagined that its culinary arrangements are efficient. Full use of these has been made, and there is an apartment for the preparation of special diet.

The gardens adjoining and the lawns of the parade front will afford ideal means of recreation in fine weather. Within the building, however, are excellent means of recreation, including billiard tables, a shooting gallery, while a large garage has been converted into a concert hall. Bright surroundings and cheerful recreation play their part in effecting "cures."

Lieut.-Col. Watt of Winnipeg has charge of the hospital. He recently returned from France, after having been eight months in charge of the Third Canadian Field Hospital. He was through the fighting of Ypres, Festubert and Givenchy, being himself wounded at Ypres. In organizing the hospital he had the assistance of Lieut. H. S. Gooderham, who is acting as adjutant. Capt. Cooper, registrar; Capt. and Quartermaster Kirkpatrick, who was quartermaster at No. 1 General Hospital at Le Treport; Capt. W. J. Hill, who was also at Le Treport; Capt. W. H. Van Norman, Capt. A. G. McLeod, and Capt. Haggie, dentist, are other members of the staff. The matron in charge is Miss Ridley, formerly of Le Touquet, with the following sisters: M. M. West, K. L. Lamkin, D. E. Winter, M. L. McCaffee, S. I. Johnson, G. V. Beers, V. N. McSweyne, J. I. Wishart and F. N. Armstrong.

At this early stage the hospital has not its full number of patients. They will be brought from other institutions when it is thought they will be likely to be benefited by the special treatment which this new institution will afford, and the staff will be increased to meet corresponding requirements.

No. 2 CANADIAN STATIONARY HOSPITAL

No. 2 Canadian Stationary Hospital, under the command of Colonel Shillington, was removed from Le Touquet to Outreau, near Boulogne, where it was quartered in a building which formerly was a large girls' school. Extra accommodation was obtained by the addition of huts, and the unit consists of eleven wards, named respectively, Quebec, Ontario, Nova Scotia, New Brunswick, Prince Edward Island, Manitoba, Saskatchewan, Alberta, British Columbia, Yukon, and Ottawa. It is now reported that the unit has been sent to Serbia. Eight thousand patients have already passed through the hospital, of whom five hundred were Canadians. The number of deaths has been small, forty-four in all. It is announced that Colonel Shillington has been appointed A.D.M.S. at Bramshot, near Aldershot, and that the unit is now under the command of Lieutenant-Colonel J. T. Clark of Quebec. It is announced also that Major H. Elliott of Cobourg has joined the staff of the hospital.

No. 5 GENERAL HOSPITAL, C.E.F.

No. 5 General Hospital, C.E.F., which left Victoria in August under the command of Lieutenant-Colonel E. C. Hart, is at present at Shorncliffe, where it has replaced the University of Toronto Military Hospital No. 4. The arrival of the unit in England was followed by a temporary distribution of its personnel. This was done for the purpose of giving employment to the nurses and non-commissioned officers until the hospital is established in permanent quarters, and opportunity of experience in British hospitals to members of the staff. As was the case with the McGill Hospital, No. 3, the personnel will be reassembled before the unit leaves England. Captain K. D. Panton, who went to the front with the 3rd Field Ambulance from Vancouver, has been transferred to No. 5 General Hospital, with the military rank of lieutenant-colonel.

SASKATCHEWAN MILITARY HOSPITAL

The following is the personnel of the Saskatchewan Military Hospital recommended by the Medical Council of the Province, subject to confirmation by the Militia Department: Officer commanding, Major H. E. Munroe, of Saskatoon, who is at present on the staff of No. 1 Stationary Hospital, C.E.F.; Major Irving, of Yorkton, and Major Meek of Regina; Captains W. Millar, of Battleford; Coles, of Regina; H. A. Stewart, of Saskatoon; Wark, of Moosomin; Craig, of Davidson; Creighton, of Estevan; Scott, of Moose Jaw; Harvey, of Regina, and Armitage, of Saskatoon; registrar and secretary, Lieutenant S. H. Braund, of Regina; quartermaster, Lieutenant P. H. Salmond, of Regina; dental surgeon, Lieutenant Dewitt, of Regina; dispensers, Lieutenants J. H. Thomson, of Moose Jaw, and R. A. Patrick, of Yorkton; matron, Miss Jean Urquhart, of Regina. The entire equipment for the unit has been ordered and probably will be assembled at a point in England. The funds for this purpose have been subscribed in the Province of Saskatchewan, and already, although all the amounts have not yet been received, over \$24,000 has been contributed.

THE THIRD AUSTRALIAN GENERAL HOSPITAL

THE Third Australian General Hospital left for England on May 19th, and, when last heard from, was stationed at Lemnos Island, in the Ægean Sea; this unit is under the command of Colonel Fiaschi, D.S.O., of Sydney, New South Wales. The 1st General Hospital, which is at Cairo, was originally under the command of Lieutenant-Colonel Ramsey Smith, head of the Health Department of South Australia. Lieutenant-Colonel Smith, however, has been recalled, and the unit is now in command of Lieutenant-Colonel H. Maudsley. The 2nd General Hospital of the Australian Expeditionary Forces is under the command of Lieutenant-Colonel T. M. Martin. According to the *Medical Journal of Australia*, up to February 3rd,

1915, the Commonwealth had contributed, in addition to these general hospitals, No. 1 Stationary Hospital from South Australia; No. 2 Stationary Hospital from Western Australia; No. 1 Clearing Hospital from Tasmania; No. 1 Field Ambulance from New South Wales; No. 2 Field Ambulance from Victoria; No. 3 Field Ambulance from Queensland, South Australia, Western Australia, and Tasmania; No. 4 Field Ambulance from Victoria, South Australia, and Western Australia; and Nos. 1, 2, and 3 Light Horse Field Ambulance Corps. A large number of members of the profession, of course, are on active service in the capacity of Regimental Medical Officers, or with the Royal and Australian Army Medical Corps.

THE ANGLO-RUSSIAN HOSPITAL

MENTION has already been made of the Anglo-Russian Hospital, which was organized in London some months ago for service in Russia as practical evidence of the sympathy of the British with the Russian people. The hospital is to be established in the Dmitri Palace in Petrograd. An advance party left England some time ago and on November 2nd, a further part of the medical staff, with nurses and orderlies, left London for Petrograd.

CONVALESCENT HOMES FOR CANADIANS

A NUMBER of convalescent homes intended exclusively for Canadians have been opened in England. During the summer months, such convalescents were sent to Bromley Park, Woodcote Park, Epsom, and to the larger hospital at Monks Horton, near Shorncliffe; now, however, that the weather is too cold for tent life, other convalescent homes have been opened, among them, Hillington House, Uxbridge, which is used as the convalescent annex for Cliveden, the Friendly So-

ciety's Convalescent Home at Dover, the Glack Convalescent Hospital at Deal, Mrs. Fleming's Convalescent Hospital at Luton House, Selling; Lady Northcote's beautiful house at Eastwell Park, Ashford, and Bearwood Park, Wokingham. Many homes have been thrown open to Canadian officers,—Nuneham Park, Oxford; the home of Sir William Harcourt; Holme Pierrepont, offered by Lord Manners; Merlewood, Virginia Water, the home of Sir Donald MacMaster, M.P., and the Moorings, Sunningdale, offered by Mr. Wills. The policy of distributing Canadians among English homes has been abandoned. It was thought that in this way the men from the Dominions overseas would learn to understand and know the people of the home land, but so many petitions have been received from Canadians asking that they might be transferred to centres where they would be with other Canadians, that it has been decided to establish hospitals and convalescent homes exclusively for Canadians. The same decision has been arrived at concerning the men from Australia and New Zealand. As for the Canadian hospitals, the Duchess of Connaught Red Cross Hospital at Cliveden, which has recently been enlarged, is staffed by members of the Canadian Army Medical Corps; the hospitals at Shorncliffe are becoming more and more Canadian—No. 5 General Hospital, C.E.F., under Lieutenant-Colonel Hart, of Victoria, British Columbia, is at the Shorncliffe Military Hospital—and the Moore Barracks Hospital and the Tent Hospital at St. Martin's Plain are staffed by the Canadian Army Medical Corps, the patients being almost entirely Canadians; the Canadian War Hospital at Walmer is devoted to Canadians, and the Helena Hospital at Shorncliffe has wards reserved for members of the C.E.F. All Canadian tuberculous patients are sent to Pinewood, Wokingham. Canadians who have been "gassed" or who are suffering from the effects of shock will receive treatment at the Granville Hotel, Ramsgate, which has been converted into a hospital; and arrangements are being made for other hospitals where special treatment will be given.

Hospital Notes

THE RED CROSS

A warm tribute was paid to the work of the Red Cross by Surgeon-General G. Sterling Ryerson in an address recently delivered at Montreal under the auspices of the Quebec Provincial Branch of the Red Cross. Speaking of the enormous quantity of supplies required, General Ryerson mentioned that during the month of June 500,000 wounded passed through one French depot alone. At the present time the British Red Cross is spending something like \$20,000 a day. The French hospitals are particularly in need of assistance, 900 of which are maintained by the French Red Cross. Three million francs a month is being expended upon assistance to women and children, and in Paris alone over 150,000 free meals are given daily. The steep roads, which are often wet and muddy, make it very difficult to use motor ambulances, and in future, especially in the winter, only those which are equipped with double rear wheels will be employed.

STE. AGATHE SANATORIUM

The sanatorium at Ste. Agathe has been placed at the disposal of the government for the treatment of soldiers suffering from tuberculosis on their return from the front. At the seventh annual meeting of the Laurentian Society for the Treatment and Control of Tuberculosis, which took place at Montreal at the beginning of November, the secretary-treasurer stated that the operating expenses had been reduced from \$11.34 a week to \$11.27 a week for each patient under treatment. The charge made is \$8 a week, and the deficit incurred last year, through the difference in these sums, amounted to \$6,000. This was met,

however, by private subscriptions. The total debt of the society is \$71,275.28. During the year 129 persons received treatment, 87 of whom were discharged. Since the institution was first opened 321 patients have received treatment, and of these 237 were alive at the time the report was made. Of the latter, 170, or 53 per cent., are perfectly well, and 67, or 21 per cent., are well but must observe care. A special vote of thanks was extended to the citizens of Abbotsford for the gift of one thousand dollars; this money was intended for the purchase of a machine gun, but when the government ceased to accept such donations the amount was given to the sanatorium at Ste. Agathe.

ST. JOSEPH'S HOSPITAL, PORT ARTHUR

The new wing of St. Joseph's Hospital at Port Arthur was formally opened on Wednesday, November 17th. It is a five-storeyed building, with roof-garden and sun-parlors, and has been built at a cost of \$160,000. The first hospital to be erected on the site of the present building was a two-storeyed building constructed in 1884, which grew out of the hospital ward established the previous year in St. Joseph's Convent for the treatment of patients from the Canadian Pacific construction camp. The building erected in 1884 was not completed until 1895, when the name St. Joseph's was given to it. It was enlarged in 1899 and again in 1905.

CALYDOR SANATORIUM

DR. C. D. PARFITT, of Gravenhurst, Ontario, who for fourteen years has been engaged in tuberculosis work, is about to have much improved facilities for taking care of patients.

A number of interested friends have recognized the need of first-class accommodation for patients and of enlarging his op-

portunities for work, and have combined to form a company to build a private sanatorium in order to satisfy these needs. The building is now nearing completion, and will be ready to receive patients in the early spring.

Calydor Sanatorium, pleasantly located on Lake Muskoka, promises to be all that could be desired for the purpose, as convenience and comfort have been most carefully studied. Present accommodation is for twenty-one patients. The rooms are large and well lighted. Each room has a private, protected balcony. Beds may be wheeled from room to balcony through French doors, so that in winter the patient may go to bed in a warm room and be wheeled out of doors for the night by the orderly. Several pairs of rooms, with private bathroom, may be thrown *en suite*, thus facilitating the association of patient with relatives. An elevator will increase the liberty of patients who can undergo but slight exertion. The building will have abundant heat for the coldest weather, and this fact, along with the conveniently arranged rooms and verandahs, will make it a pleasant place for taking the "cure" in winter. The kitchen and diet room are equipped with all conveniences for providing a good table, getting hot meals to bed-patients, and for sterilizing dishes. A modern signal system will ensure prompt attendance of nurses.

The medical equipment includes a thoroughly modern laboratory, X-ray room and throat room, and will afford all facilities for the study and treatment of tuberculosis.

Items

The Nurses' Home which has been built in connection with the Oshawa Hospital was opened on October 29th.

The Laval Stationary Hospital, No. 6, is to be increased to a general hospital of one thousand beds.

The Honorable Mrs. Graham Murray has placed her London house at the disposal of the Canadian Red Cross Society, to be converted into a home for Canadian nurses who return from the front.

The name of the Cochrane General Hospital has been changed to "The Lady Minto Hospital at Cochrane." A grant of three thousand dollars has been made to the hospital by the Executive Council of the Victorian Order of Nurses for Canada, with which the hospital is affiliated.

The annual convention of the College of Physicians and Surgeons of the Province of Quebec took place at Quebec on September 28th and 29th, under the presidency of Dr. Arthur Simard. The sum of one thousand dollars was voted to the Laval Military Hospital.

News has been received from England announcing the promotion of Dr. J. T. Clarke, who has been second in command of No. 1 Canadian Stationary Hospital at Le Treport, France, almost since the beginning of the war. He has been raised to the rank of Lieutenant-Colonel, and is now in charge of No. 2 Canadian Stationary Hospital, British Expeditionary Force, stationed at Boulogne, France. Dr. Clarke formerly practised on Bloor Street, and is very well known in Toronto.

Personals

Dr. W. E. Dean of Toronto has joined the staff of No. 4 General Hospital.

Dr. J. J. Field, of Regina, is attached to a base hospital at Eastbourne, England.

Dr. J. F. Adamson, R.A.M.C., of Edmonton, is attached to the Floriana Hospital at Malta.

Captain James Roberts, of Hamilton, is in charge of a base hospital at the Dardanelles. He has recovered from his recent illness.

Dr. A. J. Fisher of New Liskeard has been appointed captain in the Canadian Army Medical Corps and has left for active service in Europe.

Captain B. S. Hutcheson of Chicago has been appointed medical officer to the battalion of American-born of Canada, which is in process of formation.

Dr. E. V. Frederick of Campbellford, Ontario, has been appointed assistant senior surgeon at No. 1 Stationary Hospital, C.E.F., which is now stationed on the Isle of Lemnos.

Lieutenant-Colonel W. T. Connell, who accompanied the Queen's Stationary Hospital to Egypt, has returned and has resumed his duties as professor of bacteriology and pathology.

Dr. J. R. Goodall of Montreal has been appointed medical officer of the Second Brigade of the Canadian Expeditionary Forces, which comprises the 4th, 5th and 6th Canadian Mounted Rifles, now in France.

It is announced that Major F. B. Carron, M.D., has been appointed supervisor of military hospitals in England. Dr. Carron is a graduate of McGill University and was in practice at Brockville, Ontario, before leaving for England with the second contingent, C. E. F. He saw active service in the Boer War.

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NEW HOSPITAL APPLIANCES, PHARMACEUTICAL PREPARATIONS, ETC.

A Letter

DOCTOR.—When consulted by patients on the important question of the laundry, won't you bear in mind the following facts regarding Taber Laundry Works, 444 and 446 Bathurst Street, Toronto: Our laundry is one of the most up-to-date and best-equipped institutions of the kind in Canada. Every department is conducted along the strictest sanitary lines. Each and every piece entrusted to us is not only washed but sterilized, and dried with super-heated air, rendering impossible the transmission or existence of germ life. Taber Laundry Works exercise also the greatest care in not taking work from houses or places where there exists contagious disease. Our patrons are protected in this way from danger. It has been our rule for years that each and every customer receives personal attention. Telephone College 8333 and 5143 for our van service. Note.—In the past few years laundry chemists and engineers have developed the modern power laundry so that it now ranks high in the public service. Sanitation has been the mainspring of their efforts. We invite professional men and visitors to call on us. For the above reasons, we ask the endorsement of physicians.

Seed X-Ray Plates

Seed products have been standards in dry plate production for the past thirty-five years. Long experience, however, is not alone responsible for the superiority of Seed over other X-ray plates, but, in a measure, the absolute uniformity of emulsions, which insures their dependability; the remarkable gradation and detail, which is so much more essential to the successful work of the Roentgenologist than mere contrast—which does not clearly separate the tissues—all these qualities combined with extreme speed, sensitiveness and accuracy, produce in Seed X-ray plates the idea results so necessary in careful diagnostic work.

Their sensitiveness to the actinic rays of the intensifying screen has made Seed X-ray plates a favorite among Roentgenologists, and the value is especially apparent in gastro-intestinal and serial stomach examinations, where speed and gradation of shadows are of such importance. Under direct exposure, Seed plates show their superior qualities and, when used with the intensifying screen, produce snappy negatives full of brilliance and so sharp in detail that often the outline of arteries and veins may be clearly traced, at the same time recording the slightest irregularity in the tissues and bones.

Seed X-ray plates are made at Toronto by Canadian Kodak Co., Limited.

In Affections Involving Deep-seated Structures Pneumonia, Pleurisy, Etc.

A Uniform degree of Heat may be maintained for 24 hours, or longer, by covering the thorax with



Directions :— Always heat in the original container by placing in hot water.

Needless exposure to the air, impairs its osmotic properties—on which its therapeutic action largely depends.

warm and thick—at the same time allow a liberal margin to overlap the area involved.

In this way, the aggravating symptoms may be almost immediately ameliorated; the cutaneous reflexes stimulated, causing *contraction* of the deep-seated and coincidentally *dilation* of the superficial blood-vessels—flushing the peripheral capillaries. Thus the over-worked Heart is relieved from an excessive blood-pressure; congestion and pain also are relieved, and the temperature tends to decline as restoration to normal circulation ensues.

Physicians should WRITE "Antiphlogistine" to AVOID "substitutes."

"There's Only One Antiphlogistine."

THE DENVER CHEMICAL MFG. CO., MONTREAL

Frohse Anatomical Charts

THE *Journal* of the American Medical Association in a recent issue referred to these Charts in the following way: "This is an excellent series of Wall Charts illustrating the human anatomy." Up till the present the series consists of: Skeleton and joints, 2; muscles, 2; viscera of thorax and abdomen, 4; peripheral nerves, 1; circulatory system, 1 (diagrammatic); ear, 1; eye, 1; median section through head and neck, 1; histology of skin, 1. Most are of life size, while those of the eye and ear and the median section through the head and neck are considerably enlarged. They are made from paintings which were planned and supervised by anatomists. They are admirably planned to show clearly and intelligently the structures represented, and their scope includes the whole extent of those structures. They approach more closely to perfect anatomical accuracy than most representations of this kind. The painter, in making the main features stand out clearly and distinctly, has intentionally subordinated some details, as in the reduction of complexity in the arterial arcades of the mesentery. This is usually an advantage. The charts on the whole are unusually accurate, and excel in clearness, general scope and definiteness. In high schools and colleges, they would be of very great interest and instructive value. Elementary physiology can hardly be intelligibly taught without some such help, and in laboratories of anatomy they are useful, especially on account of their wide scope, in correlating the structures in different regions of the body. Their admirable planning makes them a very effective means of instruction, and their artistic excellence and clearness will insure pleasure and satisfaction in their use.

These Charts are published by A. J. Nystrom & Co., 623-633 South Wabash Ave., Chicago, Ill., and each Chart costs \$3.75.

Polusterine Antiseptic Liquid Soap

THIS preparation is made from the very purest material and will be found not to in any way injure the most delicate skin. Physicians and hospitals will find Polusterine Liquid Soap invaluable for use in the office, laboratory, or in the hospital ward. This preparation is manufactured by the Polusterine Products Co. of Canada. This firm also manufactures Concentrated Solyol, a surgical clear disinfectant. Solyol contains seventy per cent. of the higher homologues of Phenol. It is a high class antimycotic and less poisonous than Phenol, is powerfully antiseptic and disinfectant and immediately soluble in water. Its purity is guaranteed by the manufacturers. Either of the preparations named can be procured through any wholesale house.

A Boon to Institution Laundries

In these days when there is considerable trouble in reference to "help" in large Institutions, any effective labor saving device is more than welcome. One such device, which will make laundry work in a Hospital easy, is

TORO TABLETS

Their use will be found a boon, rendering the work of washing far more effective and easy. The TORO TABLET is disinfectant in character, so that no matter how mixed the articles of clothing may be, or how soiled, they come out spotlessly white. TORO TABLETS will not injure the finest fabric and no scrubbing is necessary. One tablet of TORO and half-a-pound of soap and the work is done. Hospitals supplied in large quantities at low prices.

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It is with perfect frankness, and with the utmost sincerity that, without pretending to cure every case of Epilepsy, we recommend to the medical profession **GÉLINEAU'S DRAGÉES**, which have given to their inventor the most complete satisfaction for 30 years and have earned for him the gratitude of numerous sufferers. **GÉLINEAU'S DRAGÉES** offer to the practitioner a superior weapon, giving him the possibility of a triumph in ordinary cases, and in all cases the certainty of at least a marked improvement.

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Borden Products Awarded the Grand Prize

It is interesting to know that Borden's Eagle Brand Condensed Milk and Borden's Evaporated Milk, as also several other Borden products, were recently awarded the Grand Prize (highest award) at the Panama International Exposition at San Francisco. Such an award certainly speaks volumes for the quality of these goods, and it will be a matter of satisfaction to medical men to learn that the efforts of the manufacturers to place upon the market an article that is free from adulterants of any kind has been rewarded in so deserving a manner.

An average analysis of this product for the past six months is as follows:

Fat	9.5%
Albuminoids	8.38
Milk Sugar	12.30%
Cane Sugar	40.50
Lactic Acid32
Total Carbohydrates	53.12
Mineral Salts	1.80
Caloric Value (one fluid ounce) . .	130.60 large calories.

Cowan's Cocoa

NOTHING is perhaps more refreshing for use by the convalescent sick than a pure Cocoa, properly prepared. As a sick-room beverage, it can hardly be excelled, being mildly stimulating and containing considerable nourishment. Cowan's Cocoa can be recommended by physicians on account of its high quality and absolute purity. It is made of the best selected cocoa beans, scientifically blended, and contains no foreign elements. Cowan's Cocoa is made in one of the most up-to-date factories to be found anywhere in the Dominion, a factory where sanitary conditions are at all times maintained.

Business Conducted Along Sanitary Lines

PERHAPS no class of men know better than physicians the necessity and importance of the care that must be exercised by public laundries in the handling of clothing. It would be the simplest matter for a laundry, conducted otherwise, to be the means of spreading contagion, and, unfortunately, some establishments are not as careful as they might be in collecting parcels from houses where such disease exists. Such carelessness is inexcusable and spells ruin for a firm. We have in Toronto, however, more than one laundry that use care in this connec-

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that our Products are

- (a) Absolutely pure.
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We invite Physicians to call and look over our Factory, one of the most sanitary in Canada. Every employee must keep himself or herself spotlessly clean, or otherwise are not allowed to handle any article.

CHICLETS

will be found to be a valuable adjunct in the treatment of some digestive disturbances, their use stimulating the secretion of ptyalin.

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tion, their drivers being instructed that, under no circumstances, are they to call at houses where disease of any kind is known to exist, and, if they do, are subject to immediate dismissal. One of the firms referred to is the Yorkville Laundry, 45 Elm Street, Toronto, whose watchword seems to be "Sanitation."

A Simple Prescription for "Grip"

TAKE equal parts of Listerine, Hydrogen Peroxide, Water.

Spray the nose and throat. Keep your system in good condition; observe the simple rules of hygiene, and do not trouble yourself about the presence of grip.

The above is a prominent physician's prescription for a throat wash recommended by Dr. Samuel G. Dixon, State Commissioner of Health. It is offered on the theory that an "ounce of prevention is worth a pound of cure." The use of this prescription is conducive to cleanliness, and while these ingredients will not kill the germs of pneumonia, it will go a long way in warding off the malady which just now is claiming so many victims. This remedy can be obtained at any drug store at a moderate cost.

Coryza—Acute Nasal Catarrh

This condition is manifested by a local congestion of the nasal mucous membrane, with an infiltration of serum into the tissues, and later an exudation on the part of the mucous membrane.

The local treatment calls for a remedy capable of relieving the engorgement by exosmosis, which can never be achieved by the use of acid or astringent preparations.

The use of Glyco-Thymoline in these cases purges the mucous membrane, relieving the congestion, and then by stimulating the local capillary circulation to renewed activity prevents a re-engorgement.

Drugs Badly Needed

THE scarcity of some of the most important drugs in England has become so acute that medical practitioners are handicapped greatly, especially as it is difficult to find substitutes for some medical products now unobtainable except in the smallest quantities.

This great scarcity has resulted in fabulously high prices being quoted. Thus atropine is worth between six and eight cents a grain (more than its weight in gold), while eserine is worth more. Both these drugs are indispensable in ophthalmic surgery. The scarcity of atropine is due to the dearth of belladonna, the raw material from which it is extracted, which is obtained from Central Europe.

92% OF THE HOSPITALS

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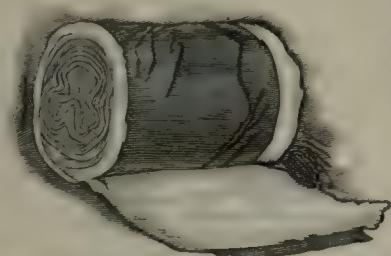
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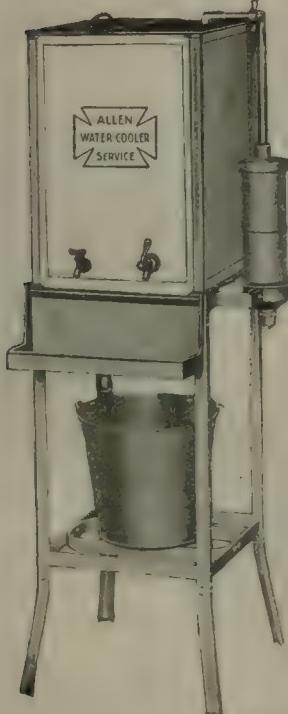


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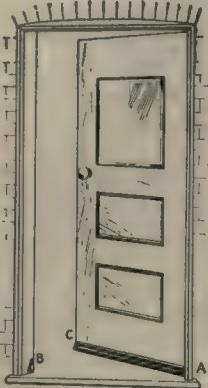
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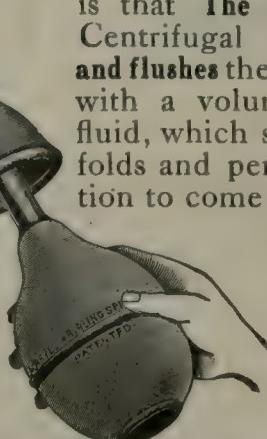
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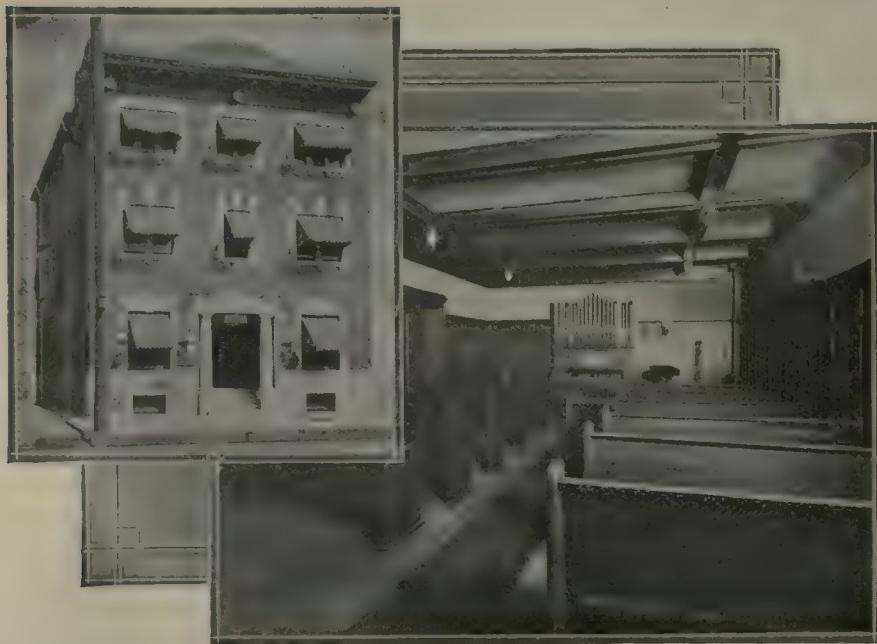
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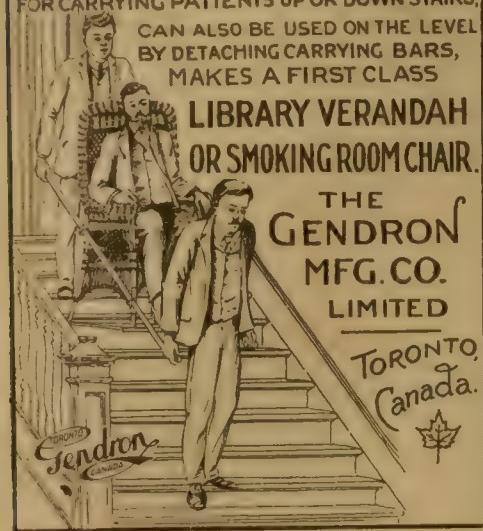
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THE HOSPITAL WORLD

Vol. IX (XX)

Toronto, March, 1916

No. 3

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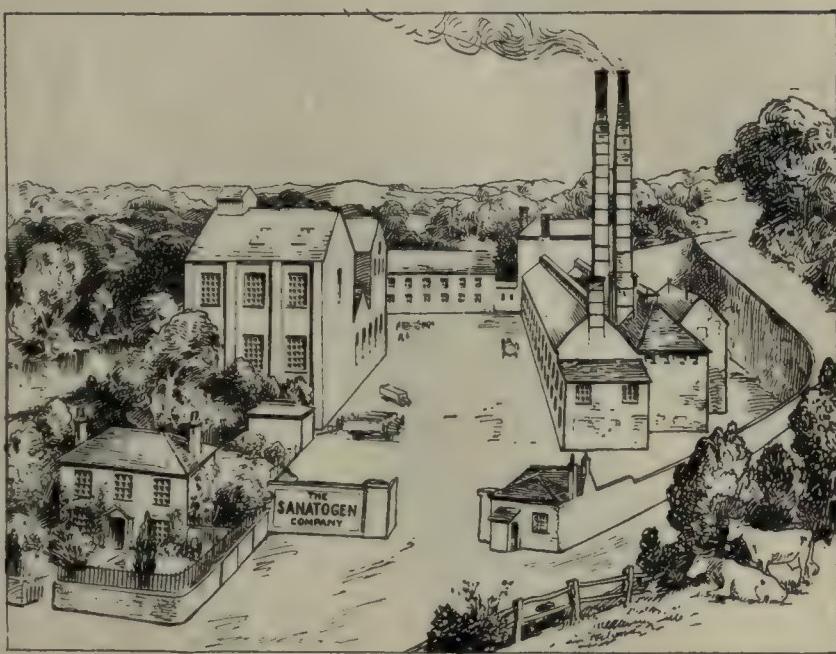
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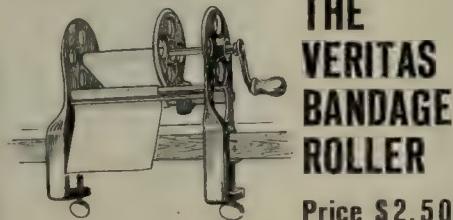
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Editorials

THE WIDER OUTLOOK

IN another column is given a brief reference to Clifford Beers' remarkable book, and of its child, The Society for Mental Hygiene.

All hospital workers will be in sympathy with Mr. Beers in the big work he has undertaken, and they should do their part in assisting, in some degree at least, this "cause which needs assistance."

And one way in which they can do this is in endeavoring to scatter the principles of the doctrines of prevention.

Preventive measures may be primary and secondary. The primary measures have reference to the prevention of drinking and the stamping out of syphilis—the two chief factors in the production of insanity, and to the inculcation of temperance in eating and in working—work mental and work physical; to the fight against those conditions which make for poverty and distress and for the social betterment of humanity generally; a more equal distribution of creature comforts among those who are entitled to them.

The secondary measures consist in the provision of first aid to those who are breaking down nervously and mentally, by the institution of social service measures in connection with hospitals, churches, schools, and the cognate agencies, and by the establishment of institutions for the reception of those who have gotten beyond the relief which can be afforded by the social service agencies above referred to.

Ann Arbor, Michigan, led the way when some seer induced the authorities to establish a psychopathic pavilion building among the other buildings

for the care of the sick in the university hospital at that place. Mosher, of Albany, also comes in for praise for his work in a similar pavilion at the Albany city hospital. Later we have the new psychopathic pavilion in connection with the Boston state hospital, until lately under the management of Dr. Southard. We must also mention the new Phipps Clinic at Johns Hopkins.

Every large city should have a pavilion in connection with one of its hospitals for the care of incipient cases of insanity.

Until the state wakes up to the necessity of taking care of these sick folk, it is up to the philanthropically disposed people to take the initiative. A long process of education will be necessary. Meantime the apostles of this new movement must use every endeavor through pen and platform to spread the gospel of mental hygiene.

HOSPITAL COOKERY

THE superintendent who took his visiting confrere to lunch at his club, giving as his reason that he didn't like the hospital cooking, gave expression to a very general attitude of hospital staffs toward the commissary department of hospitals in general.

Institutional cooking—all smell and no savor—epitomized one nurse as he ate a fragile sandwich at a private table with relish.

The hospital kitchens are equipped with spotless and up-to-date utensils and modern conveniences—porcelain soup kettles, marble kneading tables, nickel dishes and covers, marvellous food chests and refrigerators—a place of white and gold and silver shining. And yet out of it comes coarse soup, flavorless meats, heavy vegetables, and sloppy puddings, not for the delectation of the hospital staff alone, that would not matter so much, but primarily for the nourishment of enfeebled bodies, and to make appeal to the capricious invalid appetite that turns from all but the most delicate dishes.

Institutional cooking! We all know what the term implies. The condition is bad enough in the county jail and the poor house; but in a modern hospital it is or ought to be an impossible state of affairs.

Why is not the hospital soup as delicious as that clear, creamy or amber liquid found at your club, Mr. Superintendent? Why is the meat not as tender and savory, and the vegetables as succulent? And the superintendent answers that it is because there is a difference in the cooks. The club cook and the big hotel chef are masters of their art. They are often imported and command very large salaries.

The hospitals can give only indifferent pay, and must put up with indifferent cooking. None but first class men know how to cook in the large quantities demanded by an institution—whether it be hotel, club, or hospital—and yet retain in their foods

the delicate flavor of the private kitchen. That is practically the statement of the case as set forth by the much worried superintendent or steward.

How about the dietitians, one or more of whom are now attached to every progressive hospital? Thus far they have been utilized chiefly in training of nurses in food values and in the oversight of preparing special diets for private wards. This line of work is necessarily limited.

A chef may have a good knowledge of food values in addition to his culinary skill. He will rank higher in his art thereby. But the dietitian as interpreted in the nursing world to-day may be deeply versed in the chemistry of foods and their human values, and yet have but slight knowledge of cooking as an art.

In an article written during the past year by the late William Garratt Brown concerning the tubercular invalid class, to which the poor fellow belonged, he says, speaking of sanitariums: "Many sanitariums are not sanitariums at all, but mere tubercular boarding houses irresponsibly conducted for profit. I cannot from my own experience name a single one where the cookery is really good—as good, say, as one finds in the homes of 'nice' people, even those of moderate means, in America."

That seems a modest standard—the cookery in the homes of nice people of moderate means. Surely our hospitals should be able to reach it. Surely the superintendent should be able to place before his

guests a hospital meal, simple, perhaps, consisting of a few dishes, but each dish appetising and delicate, as even the club could provide, having also the comfortable sense that the hospital patients were being likewise served.

It is evidently yet a long way to the cooking and serving of the ideal hospital meal. Elaborate kitchen equipment, sanitary spotlessness, bountiful provision, and the best intention are not sufficient. These are only the husks of the meal. The kernel lies in the cooking art itself, and that is born of trained skill.

Original Contributions

LITTLE JOURNEYS

By DR. JOHN N. E. BROWN,
Superintendent, Henry Ford Hospital, Detroit.

OUR first morning in Hamburg, March 31st, was spent in using our state papers, obtained from Ambassador Hill, in Berlin. These at once received attention, and a man (Mr. Weber) was detailed to see that we had the courtesies of the city and every effort to give us the information we sought. The same afternoon we visited both of the great hospitals that have made Hamburg famous. First of these was the

ST. GEORGE ALLEGEMINES, KRAUKENHAUS (HAMBURG).

This is one of the best illustrations in the world of how an old hospital can be made new. Previous to 1898 this was a hospital of 1,250 beds. The buildings were antiquated in design and appointments. Among its faults of construction, that are pointed out in history, was that, besides a long straight row of buildings joined end to end, there were wings extending at right angles to these in such a way that the free and natural currents of air through the grounds had been rendered impossible. The work of reconstruction has been under the wise direction and sympathetic co-operation of two men who have come to be recognized as leaders in the development of hospital building the world over. One of these, Hermann Lenhardt, also eminent as a great clinician and authority on internal medicine, was especially qualified to combine hygienic and medical knowledge with practical administrative experience, since for years he was the director of that other great Hamburg hospital, the Eppendorf. The other man, Mr. F. Ruppel, official consulting archi-

From a report of a committee of the Detroit General Hospital to the Trustee Board. The committee consisted of Dr. Wm. Metcalf, Mr. Wm. B. Stratton and Dr. Homer Safford, of Detroit, the latter having compiled the report.

tect, we found a most open-minded and interesting man. Lenzhartz, unfortunately for our mission, had gone south to Algiers in search of health, which he never found. Since our return his untimely death has shocked the medical world.

The first thing that strikes one in the plan of St. George, as it is to-day, when compared with the others before the reconstruction was effected, is that the spaces between the buildings have everywhere been left open. Dr. Deneke, the director of St. George, in an elaborate description of "The New Buildings of St. George General Hospital," points with pride to the fact that there are no connecting corridors. Patients are carried from one building to another in the open air, a canvas cover being used over the stretcher when weather is sufficiently inclement to make it necessary. Considering the latitude of Hamburg, and the fact that the same observation holds good at the Eppendorf, we see from how large an experience the Germans have extensively come to the conclusion that connecting corridors between the pavilions are unnecessary.

The site of St. George is about twenty-six acres in extent, and has the advantage of an old institution in its abundance of large trees. The main avenue through the grounds is, indeed, stately.

The buildings are connected by an underground pipe-tunnel, six and one-half feet square in its cross section. In this run the pipes for steam used in heating and for the return of water of condensation. It may be noted that we were told that they approved of, and would have gladly had the combination used in the other hospitals seen (by which hot water pipes gave direct radiation in the wards), but steam had been chosen because there was not enough money available at the time to install the other. One objection they said that the steam had, which hot water did not, was noise in the pipes.

The total number of beds in St. George at present is close to 1,500. Of this number it is said that 932 are in those buildings which were built between 1898 and 1906.

The pavilion type as developed for St. George is distinct from that in Eppendorf. It is said that a two-story instead of a one-story pavilion was chosen because it was recognized

that, in atmosphere so dusty as it is in Hamburg, it would be a mistake to use for the pavilion a simple "first ventilation" (by which seems to be understood a ventilation by means of natural processes, windows, transoms and roof outlets, such as were seen in the new one-story ward pavilions of St. Jacobs, in Leipzig). And it was apparently recognized by Lenhartz that a one-story plan for so large an institution was unnecessary. St. George's, while not confined to a small site, was in the new planning limited in certain other ways which determined Lenhartz again to depart from his Eppendorf model. Instead of taking up the ordinary type of pavilion as we have seen it illustrated in Nuremberg, Charlottenberg, Schöneberg, with a single large ward to a floor, and with accessories and small rooms grouped at either end of this ward, it was decided to adopt the "two-ended" ward-pavilion, best known as we saw it in the Virchow in Berlin, although used as early as 1879 in the Academisches Krauenhaus in Heidelberg. A trial of this double-ended, two-story pavilion was made at St. George's in 1899, under the plans of Lenhartz; then later (1902-6) the similar pavilions added were perfected by Deneke in such particulars as arrangement of accessory rooms and entrances, the addition of terraces and balconies, etc. Deneke says, "The greatest advantage of this plan lies in the fact that it breaks away from the system of very large wards. While in the Eppendorf 30 beds are found in a ward, in the Urban in Berlin 32, in Friedrichshain in Berlin 28, in Frankfurt-on-the-Main 31, in Nuremberg 32, and in the Johnnestadt in Dresden 30, our wards contain only 16 or 17 beds, and this without losing the advantage of the two rows of windows opposite each other.

"The number of beds was placed at 16, because in the Eppendorf it had been shown that the one 'sister,' with the help of one 'day-nurse,' can care for 16 to 20 patients, if a separate provision is made for the night service (one night nurse to 30 or 40 patients); thus every nurse has her own well-defined jurisdiction and responsibility.

"The single disadvantage, which surpasses these exceptional advantages, is the necessity of placing, in the middle part of

the building, between the two wards, where it is built up on both sides, a short central corridor.

"Our central corridor is, therefore, as short as possible; it is about 40 feet long as against about 75 feet in the Virchow Hospital; and about 16 feet of its wall toward the south-west is formed by the glass partition of the day-room, which lets in an abundance of light, and through transoms ventilation is effected.

"Light is further admitted through glass doors on the opposite side of the corridor opening into the stair-spaces and entrance. Transoms here also favor ventilation. Also at the ends of the corridor the partitions and doors that cut it off from the ward are as completely as possible constructed of glass, so that the central corridor is anything but dark; and, in contrast with the corresponding corridor in the Virchow Hospital, is a great improvement."

It is noted that in this corridor (39 square metres) and the entrance with staircase (21 square metres), there is taken up only ten per cent. of the floor space in the pavilion. All the rest is utilized, and it is claimed that of few institutions can so much be said.

The day-room just mentioned occupies a central position alongside the corridor opposite the entrance, and extending before it on the ground floor, is a terrace, while in the corresponding locality above is a broad balcony. Alongside the day-room, on the same side of the corridor, at the one end is the nurses' room, at the other end the diet-kitchen. On the opposite side of the corridor, at the one end lies an ample treatment-room for physicians' use, and at the other end is a bathroom for patients and a small room with one bed. This simple arrangement completes the central "head-house" floor plan. At the opposite ends of the building are single tiers of small rooms. This at one end includes two small two-bed wards, and the patients' washroom and closets. The other is made up of a waiting-room and separate entrance for new patients. On one side of this entrance is the examining room, and on the other are the bath and toilet for the use of the ward-receiving department. From this bath the new patient is taken to his

bed in the ward. The two-end small wards just mentioned as at the other end of the pavilion are a feature which Deneke dwells upon at great length in praise. He finds that this location, thus remote from the busier central head-house, is peculiarly adapted to a great variety of cases not suitable to be treated in the open wards. Among such he mentions the paralyzed, the recently confined, the nervous, those with "unappetizing" affections, lupus and other eruptions, those who must be regularly catheterized or who have attacks of vomiting, and the moribund. Here, too, rheumatic patients can be protected from draughts, and for the uncleanly, ill-smelling patients, an abundance of fresh air cure can be had in the corner room with its two windows. Here, too, the fresh air cure can be carried out. Typhoid and tuberculosis can be especially well cared for here, where special appliances find room near the patient's bed.

The floor of the lower story of the pavilion is only about a foot above the level of the ground, and from the terrace opposite the entrance to the day-room a broad walk leads away to the operating building, the bath house, and to the other pavilions. For this purpose a great deal of use is made of a bed carriage, which was perfected here, and which is applied to the sides rather than to the ends of the bed, as is often seen. It is of the general type of carriage made by Maquet, in Heidelberg. The beds themselves have no casters. On these bed-carriages it is said that the heaviest patients are easily transported by the ordinary nurse without great effort, except when it is necessary to go from one building to another.

In the basement of the pavilion, which extends under only that portion of the head-house occupied by the central corridor, the day-room, the diet kitchen and nurses' room, there are two small rooms for soiled linen, connected separately by chutes with the two stories above. There is also a large store-room for the patient's clothing, which is placed here in bags after being brought from the disinfecting station.

On the question of chutes for the soiled clothes, Deneke says:—"The question whether we ought to put the chutes into our new building has been the subject of extensive deliberation. In many ways these have been a source of complaint. They

are said to be difficult to keep clean, and on being opened are apt to convey upward draughts of ill-smelling air. These shortcomings are well known to me from my own experience in Eppendorf, and the first chutes employed in the reconstruction of St. George had the same shortcomings to a marked degree. In this matter, as in so many difficulties, the advice of our first (leading?) medical and technical counsellor on matters of hospital hygiene, Medizinalrat Kohler of Offenbach, gave us assistance. Kohler advised us to make the diameter of the chute at least 2 ft., to make the inner surface smooth, and, after the walls are thoroughly dry, to cover with enamel. Furthermore, in the room below, into which the linen falls, the doors and windows should always be kept closed. And this is right, for the disadvantages have always appeared under conditions where narrow chutes, for the most part constructed of sheet iron, end in a receptacle of wire netting which stands out in the open corridor or similar location. By the use of separate rooms in the cellar, the windows and doors of which are opened only once a day when the washing is sorted, we have definitely avoided the draughts of bad air coming up the chutes, and think very highly of the arrangement in this form. It is, indeed, a great satisfaction, to remove the soiled linen quickly from the neighborhood of patients."

Opening out of the general pipe-tunnel, into a small room beneath the end of the pavilion, is a door through which the engineers come to attend the heating apparatus. The room can also be reached from the outside of the building by an outside stairway, but there is no connection with the interior.

The spaces beneath the wards are only about 31 in. deep, and are the warming chambers of the air for ventilation, which enters near the centre from a canal at the lower level that pipes the fresh air from out of doors at either side of the building. It is claimed that the warmth here serves the further purpose of warming the floor of the first story directly.

The floors in the wards, and in all the rooms where there is much walking, are of hexagonal Mettlach tile. On the terraces and in the halls these are worked into patterns in yellow and

red. In the small rooms, the nurses' room, and some of the day-rooms, the floors are of cement, covered with heavy linoleum. All coves and corners are rounded. In rooms with linoleum floors the under-layer of cement is rounded out to form the cove, and the linoleum is carried upward on the wall for about 5 inches, where a strip of brass protects its upper edge and forms a perfectly smooth transition to the wall surface above. The application of this method of finishing is said to be especially difficult, but when well done is extremely satisfactory. Linoleum has the advantage of being impervious, smooth, easy to the feet and more noiseless than any floor except the more expensive rubber. However, furniture in these rooms ought not to have metal casters or sharp-cornered feet. In spite of this disadvantage the oak floor, or the use of such composition as xyloin, torgament, or eylopal, have not been held more desirable.

The stairs are 4.5 ft. wide, with risers of 7 in. and treads of 12 in., an especially easy stair being held here more desirable than elevators, of which very few are used in the institution, although the new pavilions are all of two stories.

Doors all through the pavilions, except diet kitchen and toilets, are full width and provided with protecting bars, so that it will be possible for patients to be carried about in their beds. No doors are made double, i.e., half at either side of the doorway, because it is held that to hold two doors open while the patient is being taken through requires too much time. Then single, full-width doors are 4 ft. wide, while the beds with their carriages are a little less than 3 ft. The door is made of fir, as is most of the woodwork in the pavilion. All doors leading to the central corridor, as above described, are filled with large panes of glass.

To further facilitate the carrying of patients, whether on stretchers or beds, through these wide doors, a fixture at their upper edges is so arranged that, if the door is opened to its full width, it is caught and held until the patient has passed through, when with a light touch of the foot the nurse or orderly can free the door, so that it closes itself without further attention.

In transporting patients to and from the upper story as above mentioned, elevators are not generally used. A form of stretcher suspended by straps from the shoulders (though also steadied by the hands) is used for the purpose by two orderlies.

The door-casings are not of wood, but are covered with white Mettlach tiles. The doors themselves close into a groove and are hung from a frame of L-iron, which is anchored in the cement. The tiles are joined flush with the frame. As early as 1899 this plan was used here, and was found to render cleanliness much easier to effect and the appearance afforded is pleasing.

Windows are of the type known here as "box-windows," i.e., they have a double glazing. If properly constructed, it is said no dust will accumulate between the two panes and no cleaning is ordinarily necessary on this side of the glass, though the inner pane is hung in a light separate frame hung to the main frame. The windows here are generally 9 ft. 4 in. high and 4 ft. 7 in. wide, and reach nearly to the ceiling. The upper quarter of the window is separated from the rest by a bar, and this upper part, closed by a transom, is single glazed. The Regner patent lock has proved satisfactory, and is especially convenient in management, and the clamp generally succeeds in keeping the sash from rattling even in a strong wind, though every fixture should be carefully tested before being accepted. The lower windows are provided with a simple lever lock, with plain brass handles.

Low pressure steam is the means of heating. The steam generated at a central boiler station, is transmitted at about six atmospheres pressure through pipes in the underground tunnel to the separate buildings. At the building the pressure is reduced. As described above, the floor of the lower ward is incidentally warmed by the radiators in the air-chamber beneath it, as is the upper floor by the warmth of the lower ward. From the large, low warming-chamber beneath the floor the fresh air which has entered through shafts at the outside of the building, passes upward by flues in the wall, which discharge into the room half-way between the floor and ceiling. Foul air is withdrawn by other wall flues, which pass out

through the roof. The openings into these latter flues from the ward are through the side wall both at the floor and at the ceiling, the former being intended for use in winter and the latter in summer. Deneke expresses the opinion that the system would be better without these upper openings:—"They are difficult to keep clean, inconvenient to open and close, and lead in winter, if not properly closed, to faulty renewal of air in the lower part of the room," as well as being wasteful of heating materials.

The ward dimensions are 44 ft. by 30 ft., with ceilings 13 ft. 6 in. high. The floor space for each of the sixteen beds ordinarily found in a ward is 84 square feet, and the cubic air space is 1,134 cubic feet per bed. On each of the opposite long sides of the ward are five windows like those previously described. The ratio of window surface to floor space is 1:3.

The bed is of the model described by Schottmuller, with minor alterations, and was supplied by the firm of C. Aug. Schmidt Sohne, Hamburg, Uhlenforst, Herderstrasse. The mattress is divided into two portions, one twice the size of the other. This mattress, made of wool, is a special feature of the Hamburg hospitals, and is claimed to be very pleasing to the patients; warm, comfortable, easy to handle, to clean and disinfect. Although these now cost considerably more than when the Eppendorf institution was equipped in 1888, they are still materially cheaper than hair mattresses.

The writing table, used for eating and reading by the patients, is an especial virtue of the St. George bed. When not in use it is left in place upon the lower side bars beneath the bed. Here they are out of the way, and are not low enough to interfere with cleaning the floors. Besides this bed-table, there is the ordinary small square table, with one drawer and two shelves below, which stands beside the bed. The electric lamp by which the patient may read, write or work in the evenings is of the swan-neck pattern, which will stand upon this table or be hung above the bed upon the wall, as the patient may choose. This pattern has given here especial satisfaction.

The use of the space in the centre of the ward here is of interest. The construction of the building is such that one

small pillar is at the centre of the ward, and upon this pillar is placed at one side a small oblong sink and at the other side a washstand of pleasing finish; brown marble said to be better than porcelain, because the latter is apt to chill. Farther toward one end of the ward is the medicine chest, a most compact and complete receptacle for anything the nurse may need in dressings or drugs. Its top is of Bergian marble. Toward the other end of the ward stands a table for the use of the house doctors or nurses in making records.

Speaking of the advantages of this arrangement, and especially to the central washstand, Deneke says:—"Not only is this the point most quickly reached—one cannot scorn even the small saving of time, if often repeated—but it is also desirable that the patients see that the physicians and the nurses wash their hands after examinations and procedures for treatment, as well as how they do so."

In one particular this institution has made a somewhat radical departure. Besides the general effort common in all the new hospitals to have the fixtures simple in design, and with no places where dirt can accumulate they have given up the common custom of nickel-plating them. This is because it is held that nickel-plating is short-lived anyway, and that a proper daily cleaning will keep brass looking as well as same can do when covered with nickel.

Another feature of ward furniture is the screens (or windschirmen) made of linoleum, set in light frames of wood.

In the washroom at the far corner of the ward, next to the small two-bed wards, are all the conveniences of patients able to be up about the ward. In the ante-room of the closet is a small door in the outside wall, which opens into a case of shelves, on the other side of which a zinc grating and an iron door open out of doors. Upon these shelves are placed receptacles (bed-pans, etc.), containing specimens of feces, urine, etc., which are being preserved for medical inspection. This niche in the wall is about 15 ft. wide and 16 ft. high, extending through the wall, and is lined with glazed tiles. The shelves are easily removed for cleaning the cabinet.

In the toilet, the closets are placed in the direct light immediately beneath the window.

Returning to the central "head-house," we note that the room on the lower floor devoted to the supervisor nurse is on the upper floor occupied by two nurses on duty in the pavilion. These rooms are made pleasant and suitable as living and sleeping rooms. Only a part of the nurses, however, are thus provided for, the rest live in the nurses' home, and all go there for meals.

The day-room, which is 14 ft. x 18 ft. in size, is made to be a living room for the patients who are able to go about. Here are tables for meals and games. The partition which separates this from the corridors, for reasons before mentioned, is of wood for only about four feet above the floor, the rest of the way to the ceiling being of glass. In passing through the outer door we go out upon a terrace below (a balcony above), which is 10 ft. x 44 ft., and serves as a place for taking patients out of doors. The balcony along the upper story is only about half as long as the terrace, leaving the greater part of the terrace open to the light. Upon these terraces and balconies the hand food-cars are used, as in the wards, to bring the patients' meals to them.

The diet kitchen is 11 ft. x 15 ft., is provided with heaters, gas stoves, a wash sink, cupboards for dishes, etc. Here every patient's tray is made up.

The treatment room, on the other side of the corridor on the ground floor, is claimed to be a most valuable feature, and an often omitted one, in the pavilion. The complexity of the requirements for examining patients is so great that this should be ample in space. apparatus for investigating and treating the internal organs, the nose, ear, throat and genital organs must be brought together at one place. The relief of effusions in the pleura and pericardium is carried out here. In the surgical and gynecological divisions, these physicians' rooms serve also as dressing-rooms and for the carrying out of smaller operations; moreover in these rooms all case histories are taken. The very ill patients are brought hither in their beds. The room is about 15 ft. square. It is equipped with two washstands

with roomy bowls, an enamelled wash-sink, a dressing and instrument cabinet made of glass and iron, a drug and reagent chest, a portable instrument case, a portable double wash-bowl, a Schagintweit's pocket for soiled linen, a steam sterilizer under a hood, a dry heat sterilizer (up to 180°), Bunsen burner, a dressing table, etc. A high window, 10 ft. wide, facing north-west, furnishes light for the room. The lower portion is of frosted glass, the middle part of wave-glass, and the upper clear and plain. By means of dark blue hangings the room can be conveniently darkened.

In any room, wherever the smallest amount of gas is burned, especially in the presence of chloroform for narcosis, careful attention must be given to provide ventilation channels for the products of combustion. This sometimes affects not only the air to be breathed, but it may happen that the products of combustion of gas attack nickel-plated objects, so that they cannot be made white again by polishing. This is due to the sulphur in the by-products of combustion.

Above the treatment and examining room just described, the corresponding space on the second floor is occupied by a large bathroom. Here are two sheet-steel nickel-plated bathtubs, a clothing warmer, the usual arrangement for sprays, a foot-bath, sitz-bath and two washstands. This room is on occasions available for examinations and treatments in case the one below is in use.

Finally, an important though small room in the second story is devoted to storage of the various articles needed in the ward, such as step-ladders, air-cushions, large splints, electric sweat-baths, measuring instruments, and things too large to find place in a small cabinet. Here, too, are a reagent-table, to enable the nurses to carry out simple urine tests. It also makes a place for the soiled linen receptacle. Next to the window, cut off by a low partition, is a closet for the women employed in the pavilion.

Receiving wards are provided, one on the male and one on the female side for each service, medical and surgical. This is an important service which is not turned over to the less experienced house-doctors, but is held for years by men who, by

the extensive experience afforded, become very skilful, not as specialists, but as general observers. They are often called upon to give the first treatment in cases over a wide range of practice.

For the purpose of an admission ward, one of the four wards in a pavilion is used, and that the one on the ground nearest the street. Here is the special entrance before mentioned, entering the waiting room, 13 ft. square at the centre of this end of the pavilion. Also, as previously described, are, at the left the bathroom for new patients before entering the ward, and, at the right, the physicians' examining and treatment room, also 13 ft. square. This latter is provided with a somewhat less complete equipment than that for the regularly received patients, in the central part of the building.

The receiving ward is provided with a few beds for children. There is a writing table and a microscope table, and fresh preparations and other materials are studied at the bedside in this receiving ward. The small single room on the central corridor is used in connection with the receiving ward. In the third story of the pavilion containing the receiving wards, and over the central head-house, are added another floor of rooms occupied by the house medical staff.

Registrar of Vital Statistics, Saskatoon

A request was recently made to the Provincial Government that Dr. Arthur Wilson, Medical Officer of Health at Saskatoon, should be appointed Registrar of Vital Statistics. The request, which has not been complied with, was made because it was considered that were the Registrar of Vital Statistics also an official in the Department of Public Health, the work of the two departments would be facilitated and co-ordinated. The matter was discussed in a general way at the last convention of the Canadian Public Health Association and a resolution was then passed in favor of the appointment of Medical Officers of Health as Registrars of Vital Statistics.

Selected Articles

A HOSPITAL'S LIABILITY FOR THE NEGLIGENCE OF A NURSE

THE case of *Levere v. The Smith's Falls Public Hospital*, decided during the present month (December, 1915) by the Appellate Division of the Supreme Court of Ontario—the highest court in the Province—is of such importance to hospitals that we have obtained copies of the judgment.

The court was composed of the Chief Justice of the King's Bench (Sir Glenholme Falconbridge) and Riddell, Latchford and Kelly, J.J.

The decision was unanimous in the result; each of the judges gave his reasons in writing; and as the written reasons of Mr. Justice Riddell include all that is contained in the others we shall here give an outline of that judgment.

Riddell, J. "The Smith's Falls Public Hospital is an incorporated body conducting a public hospital in the town of Smith's Falls; there are no shareholders or capital stock, and the institution is conducted not for private profit, but simply as a public charity and for the benefit of the community—a most admirable and commendable object.

The plaintiff, Mrs. Levere, suffering from *prolapsus uteri*, was advised by her physician, Dr. G., to go into the hospital and be operated upon. She accordingly went to the hospital of the defendants and selected her room, agreeing to pay \$9.00 a week, "to include her board and attendance and nursing."

She was operated on (successfully) under an anesthetic by Dr. G., Dr. F. assisting; and then she was taken to her own selected room and put to bed, still unconscious. On recovering consciousness, she felt a severe pain in her right foot; and on the surgeon being sent for he discovered a serious burn on her right heel about the size of a fifty-cent piece; a blister had formed. Dr. R. thinks the burn must have been at least a quarter of an inch in depth. The plaintiff was treated properly

and she left the hospital at the end of seven weeks with the burn about healed; but she still has a scar at the locus of about an inch by an inch and a half. This is not only painful, but also disabling; there does not seem to be much hope of improvement unless an operation be performed, and the result of such an operation is doubtful.

She brought an action against the hospital, which was tried before Mr. Justice Britton at Brockville, May 26th, 1915; the learned judge decided in favor of the defendants (34 O.L.R. 206), and the plaintiff now appeals.

There can in my mind be no possible doubt that the burn was caused by an overheated brick being placed against the foot of the anesthetized and unconscious plaintiff; that this was done by the nurse in charge, and that such an act was improper. There can be no doubt of the liability of the nurse civilly unless she can justify herself by the command of someone she was bound to obey; but the nurse is not sued here. The sole question is whether the hospital is liable for this act of its nurse.

The matron was the head of the nursing staff; a trained nurse herself, she was the superintendent of the nurses; she selected the nurses, hired and discharged them, subject to the approval of the Board.

The nurses, in addition to board, etc., received a "honorarium" in money ("honorarium" which really means a gift on assuming an office, is now often used as equivalent to "salary" by those who do not wish to think they receive wages). The particular nurse to wait on her, the plaintiff had nothing to do with selecting. The matron appointed her to that particular work, and she never became the servant or employee of the plaintiff, but continued the servant and employee of the hospital; she was sent by the hospital to perform for the hospital its contract to supply the plaintiff with nursing.

In the absence of authority and of special circumstance, it would be plain that the hospital is liable for her act. The cases will be examined after dealing with the circumstances most relied upon by the defendants.

It is contended that the nurse was under the orders of the operating surgeon; that she carried out his orders, and conse-

quently the hospital could not be made liable. But this implies a state of affairs which does not exist in the present case.

If the nurse obeyed the express order of the surgeon she was not guilty of negligence at all—that is the duty of a nurse. Of course, she must take some pains to see that she quite understands the doctor's meaning and must not act on what she should know to be a slip of the tongue. To put it in other words, the order she obeys must be a real order, not such as is an apparent order but so expressed that it cannot be supposed to set out the doctor's real meaning.

A nurse holds herself out to the world as being possessed of competent skill and undertakes to use reasonable care. If the command of the surgeon is plainly a slip, she should call his attention pointedly to the order. When his attention has been called to the order and he shows that the order made was that intended, she may obey; "he is the doctor," and it is not negligence for a nurse to act on the belief that he is the more competent.

In *Armstrong v. Bruce* (1904), 4 O.W.R. 327, the nurse contended that the surgeon had ordered her to fill the "Kelly pad" upon which the unconscious patient was to lie, with *boiling* water. She did fill it with boiling instead of hot water, with the result which was to be expected. The patient sued the surgeon for damages; the defendant and other surgeons swore that the nurse had been told to fill the pad with hot water (not *boiling* water), and the trial judge believed them. My learned brother (the present Chief Justice of the Common Pleas) said, p. 329: "I have no manner of doubt that if the doctor had said to any experienced nurse that she was to fill that pad with *boiling* water it would have struck her as an extraordinary thing and one calling for some explanation. . . . It was a thing that could not have been done by Dr. B. unless through a slip of the tongue."

Of course, a surgeon could not shield himself from the result of an improper order. He has at the operating table no more right to make a slip of the tongue than a slip of the knife, and must guard against both equally.

But granted that an order is a real order of the medical man, a nurse is justified in obeying it unless it is plainly dangerous; and not being guilty of negligence herself she cannot by so acting render her employers liable for damages for her acting in accordance with such an order.

Here the facts do not bring the nurse into such a condition.

Where a patient is, or has recently been under an anesthetic, there is a standing order in all hospitals to keep the bed warm; "it is," says the matron, "a standing order to warm the bed"; this is taught by "the doctors originally training the nurses." The nurse under whose charge the patient is attends to the heating of the bed, and to the heating of bricks, if bricks are used for that purpose. It was the duty of the nurse "when she was told that she had charge of the room where the patient was . . . to see that the bed was properly warmed," and, "the doctor would not give her any direct order." Of course, if the doctor finds the bed not such as he thinks it should be, he may give such orders as he sees fit, and these orders must be obeyed; he does not ordinarily inspect the bed. As I have heard it said by a very eminent surgeon: "If I cannot trust my nurse I must give up surgery."

My learned brother at the trial put it quite accurately as follows:

"His Lordship: That narrows it to this extent, it is the duty of the nurse in the first place to do as suggested to her, in seeing that the bed is properly warmed for the patient, and then if the doctor comes in it may be his duty to see if it is over-heated or under-heated, and gives his directions in regard to that, but in the absence of any directions in regard to that it stands that it is the nurse's duty."

There is much evidence, more or less loose, about this nurse being under the doctor's orders, and the like; but the above fairly represents the result of the evidence taken as a whole.

In the present case the operating surgeon assisted in placing the patient in her bed after the operation, but took it for granted that the bed was properly heated, made no inquiries and gave no orders—and, indeed, such was the usual course; "they" (the doctors) "consider them" (the nurses) "all right, competent."

It cannot, therefore, be successfully contended that the nurse in placing as she did an overheated brick to the foot of the patient was following the doctor's orders; and it is quite clear that he knew nothing about what she did and that he gave no directions of any kind.

The main contention, however, of the defendants is that they are not liable for the negligent act of the nurse, and many cases are cited in support of that proposition."

His Lordship then examines the cases in England, and shows that there the true test is declared to be whether the defendants undertook to supply nursing or only the nurse—if the defendants' contract was only to supply a nurse to do the nursing they were not liable if they had used due care in selecting a nurse. Moreover, the defendants would not be liable in the English law if the negligence of the nurse took place in the operating room. "As soon as the door of the theatre or operating room has closed on them for the purposes of an operation, or an examination, the nurses cease to be under the orders of the defendants inasmuch as they take their orders during that period from the operating or examining surgeon alone."

The Irish cases relieving hospitals from responsibility are shown to depend on the statutes governing Ireland, while the Scottish cases refer only to the negligence of the surgeon, for which the hospital was considered not to be liable.

In many of the American States the theory of the law was that a hospital conducted or a charity supported in whole or in part by contributions, public or private, and not intended to make a profit, is charged with a trust for all its money and property, and therefore cannot be sued so as to take away any of its property from its intended purpose. This is the law of Massachusetts, Pennsylvania, Michigan, Ohio, Maryland and (at least in the absence of a special contract) New York. Rhode Island also has come round to that doctrine by the effect of an express law. The latest American case cited was during the present year in Alabama. There the court held that the hospital was responsible to the fullest extent for the negligence of its nurses.

The same law is laid down in British Columbia.

His Lordship then proceeds thus:

"The only case in our courts of which I am aware did not go further than the trial court. If the law was there correctly laid down—and I think it was—it would be conclusive of the present case in favor of the plaintiff. It is, however, not binding upon us; and it is not necessary in the present case to go so far as was done in that case.

In *Everton v. Western Hospital* there was no special contract, the patient being admitted in the usual way to the Western Hospital, Toronto. He was a somewhat dissipated individual, and was suffering from pneumonia. He was placed in a ward on the top flat of the hospital building, about twenty-five feet from the ground, which at the time was frozen hard.

The nurse on duty was proved to be very careful, skilful and conscientious. She had been in the ward, looked at the patient carefully, and found him quite quiet and apparently asleep. She then went out quietly into the hall to do something, but was still near the patient. Unfortunately, after this visit by the nurse, he got out of bed and made for the window, which he opened. He was going out head foremost when the nurse rushed in and seized him by the nightdress; unfortunately it gave way, or she lost her hold. He sustained a fracture of the skull, and died. February 14th, 1903. The wife brought action, and the case was tried before Mr. Justice Britton and a jury at the Toronto jury sittings. A verdict of \$250 was awarded the plaintiff against the hospital. There was no appeal.

* * * * *

After all the cases it is plain that once the "trust fund theory" is got rid of—and it is conceded that it has now no footing in our law—the case is reduced to the question, What did the defendants undertake to do? If only to supply a nurse, then supplying a nurse selected with due care is enough; if to nurse, then, the nurse doing that which the defendants undertook to do, they are responsible for her negligence as in contract—*respondeat superior*.

I am of the opinion that the plaintiff should succeed.

The only question remaining is as to the amount of damages to be awarded.

The patient, who should have left the hospital in two weeks, was forced to remain seven; she was then unable to walk and had to be carried out of the hospital; for more than four weeks she sat in a chair, and when she put her foot to the ground the leg would swell so as to require bandaging; a consultation of doctors resulted in the advice to return to the hospital, she being then just able to hobble, putting a little weight on the toe; she remained in the hospital nearly two months, slightly improving, but not permitted to put weight on the foot; even at the end of the time she was compelled to use a crutch; and now, many months after, and after treatment with electricity, etc., is still lame, the foot being very painful at times; she is forced to have a pillow under the back of the heel in bed or she could not sleep. Dr. G. thinks that the pain is caused by the implication of the nerve in the scar tissue and that an operation would be of advantage. Dr. R. once was of that opinion, but after consulting some who he thinks know more than he does and who have a different opinion, can only say: "My own opinion is still that there is a possibility of something being done by an operation.

. . . It is very questionable whether an operation would be beneficial or maybe make it worse"; and he gives reasons. Dr. F. has his own opinion "that if this pain was being caused by a nerve fibre caught in the scar, as I supposed it was, that if it could be severed it might stop the pain."

After an examination of the cases, I laid down the rule in Bateman v. Co. of Middlesex (1911), 24 O.L.R., 84, at p. 87, that, "if a patient refuse to submit to an operation which it is reasonable he should submit to, the continuance of the malady or injury which such operation would cure is due to his refusal and not to the original cause. Whether such refusal is reasonable or not is a question to be decided upon all the circumstances of the case." This rule was not questioned by the Divisional Court or the Court of Appeal; 25 O.L.R. 137, 27 O.L.R. 122.

Dr. R., the plaintiff's own physician, who had attended her before and after being in the hospital, cannot do more than say the operation might do good and might do harm. He does not seem to have advised it. In these circumstances it cannot be said that the condition of the patient is due to unreasonable

refusal to undergo the operation. Were I permitted to draw on my own experience I could tell of a patient who refused to allow his arm to be amputated—the surgeon advising the operation, but saying he could not be quite certain that it would do good. The patient made an excellent recovery, with the arm almost as useful as before.

Little evidence is given of pecuniary damage. Perhaps most of such damage is that of the plaintiff's husband, who is not a party to this action, and whom we must leave to bring his own action if so advised.

But the pain and disability, past, present and future, call for a substantial assessment of damages; and with every regard for the defendants' position as a most estimable charity, I think the sum of \$900 cannot be regarded as excessive.

The appeal should be allowed with costs and judgment entered for the plaintiff for the sum of \$900 and costs.

It may not be amiss to add a few statements:

(1) We proceed on the ground of an express contract to nurse, and express no opinion as to the law in the ordinary case of a patient entering the hospital without such contract.

(2) As a corollary of the above (while we think an implied contract has the same effect as an express contract in the same terms) we give no opinion as to the contract implied from a patient entering a hospital.

(3) We express no opinion as to what the result would have been had the negligence occurred in the operating theatre.

(4) None of the cases in any of the jurisdictions expresses any doubt that, whether the hospital is or is not, the nurse is liable for her own negligence in a civil action; in some cases also criminally for an assault, simple or aggravated, and in fatal cases for manslaughter.

(5) There is no hardship in the present decision. The hospital can protect itself, as was done in *Hall v. Lees*, and in some of the American cases.

Hospital Notes

It was decided at a recent meeting of the Calgary Hospitals' Board to reduce the charges made by the Hospitals to patients from country districts. It has been customary to charge such patients one dollar a day more than patients from the city of Calgary itself.

The Sanatorium at East St. John was formally opened on December 9th. Accommodation is provided for fifty-three patients, and consists of a public ward containing thirty-two beds, a children's ward with eight beds, and rooms for private patients. The Hospital is intended for patients suffering from pulmonary tuberculosis from the Municipality and City of St. John. Should there be vacancies, however, patients from other parts of the Province will be admitted. Dr. H. A. Ferris is the Medical Superintendent.

Lt.-Col. C. A. Peters, Montreal, has been given command of No. 9 Field Ambulance, which is being recruited at Montreal. The officers of the unit are, Maj. Bazin, second in command. Maj. W. B. Howell, Captains H. H. Eyres, J. C. Tull, D. Waterson, F. J. Tees, A. Ross, and W. G. McLachlan; and Lt. J. C. Pratt, Quartermaster. In addition to the officers the unit will have a rank and file of 248, including the members of Section A of No. 2 Field Ambulance which has been in training at Sherbrooke under Capt. Eyres.

The following is the list of officers of No. 7 Overseas Stationary Hospital: Officer Commanding, Lieutenant-Colonel John Stewart; Majors E. V. Hogan and L. M. Murray; Captains J. A. Murray, V. M. Mackay, F. V. Woodbury, E. Kirk

Maclellan, John Rankin, Kenneth A. MacKenzie, S. J. MacKenzie, D. A. MacLeod; Honorary Lieutenant Walter Taylor, Quartermaster; Lieutenant K. F. Woodbury, Dental Surgeon; and Honorary Lieutenant S. R. Balcom, Dispenser. The Unit was offered to the Militia Department by Dalhousie University and several of the officers are members of the Medical Faculty of that University; the non-commissioned officers and men have been recruited from the Province of Nova Scotia, and many of them are students of Mount Allison, King's College, Acadia, or Dalhousie. The Unit was mobilized at Halifax and is at present in training there. It is hoped to collect the sum of \$12,000 for additional equipment and maintenance of the Unit, and a committee has been formed consisting of Dr. G. B. Cutten, President of Acadia University; Dr. H. S. Mackenzie, President of the University of Dalhousie; Dr. B. C. Borden, President of Mount Allison University, and others, to direct the disposition of the funds subscribed. Mr. C. W. Frazee, Manager of the Royal Bank, Halifax, has consented to act as treasurer of the fund.

Women's College Hospital, Toronto

A REGULAR meeting of the staff of the Women's College Hospital was held on January 28, 1916, Dr. E. R. Gray presiding.

Doctor Smellie reported that four physicians were ready to begin clinics at the Hospital in obstetrics, gynecology, medicine and pediatrics, respectively, as soon as the Board of Directors should complete accommodation for them.

It was decided that the Secretary make inquiries as to the advisability of changing the hour for the clinics being held at 18 Seaton Street, so that clinics might be run concurrently at an hour convenient for both physician and patient.

A report from the obstetrical staff was read, stating that they were anxious to keep full records of every obstetrical case in the hospital, and urging the physicians on other services to co-operate in the case of private patients. Doctor Hamilton was appointed registrar of this section.

Doctor Hume then gave a very interesting paper on "Twilight Sleep," based on a study of the reports of two thousand

cases. In the discussion which followed Doctor Brown gave some conclusions which the Rotunda Hospital had arrived at as regards this treatment. The meeting closed by adjournment.

Administration Building for Hamilton Hospital

ON account of the over-crowded condition in the General Hospital, Hamilton, it is likely that an Administration Building will be erected at the new Mount Hamilton Hospital in the near future. The General Hospital funds, we are glad to know, show a surplus of between ten and twelve thousand dollars for 1915.

Another Military Hospital for Toronto

OLD KNOX College, which occupies the centre of Spadina Avenue, just north of College Street, and has been for so long identified with Canadian Presbyterianism, is to be a Convalescent Home for returned soldiers. This arrangement was concluded by Colonel Marlowe and his associates two weeks ago. The building will be completely renovated and be ready for occupation within a few weeks' time.

PERSONALS

DR. E. H. YOUNG, late of Rockwood Hospital, Kingston, has been promoted to the position of Assistant Superintendent of the Hospital for the Insane, London. Dr. W. K. Ross, of the Hospital for the Insane, London, has been transferred to Rockwood Hospital, Kingston.

Dr. G. F. Dewar, Charlottetown, P.E.I., has been appointed Acting Medical Superintendent of Falconwood Asylum during the absence of Doctor Goodwill on active service.

Dr. Robert Hanley, Kingston, has been appointed Surgeon of the Provincial Penitentiary in succession to Dr. Daniel Phelan. Dr. Hanley will continue his private practice and will receive an honorarium of \$1,300 a year instead of \$2,400 received by Dr. Phelan, who, however, was not able to engage in private practice.

Book Reviews

A Mind that Found Itself. An Autobiography. By CLIFFORD WHITTINGHAM BEERS. Longmans, Green & Co., 38th Street, New York, London, Bombay, Calcutta and Madras.

This book has now reached its third edition. We hope it will reach many more.

Mr. Beers was a bright young man, graduated from Yale, who suffered from an attack of manic-depressive insanity caused, he avers, from the prolonged fear of his one day becoming an epileptic, a disease to which a brother had previously succumbed.

Mr. Beers was incarcerated for several years in sanatoriums and state hospitals.

Mr. Beers one day was suddenly cured, apparently reasoned out of his chief delusion by a brother.

Mr. Beers' experiences, kindly and brutal, were vividly impressed upon his memory, and they are fully and strikingly reproduced in his story, which is truly a human document of the most absorbing interest.

Mr. Beers has undertaken the establishment of societies for mental hygiene, for the prevention of insanity and for the better care of the unfortunate people who become insane.

Doctor Beers' work is endorsed by such men as the late William James, Thos. R. Lounsherry, Dr. Lewellys Barker, and the editors of the *Review of Reviews*, *Journal of the American Medical Association*, *North American Review*, *American Journal of Insanity*, and other leading periodicals.

There is a parent society, which has been in existence for several years, but branch societies are being established in a number of states. It is to be hoped that speedily all the states of the United States will become organized.

With an insane population of over 200,000 in the States, it is time something ought to be done.

Beers' book has been characterized as "the inspiration of the mental hygiene movement." We trust it will have a very wide sale. It can be procured from the Longmans direct for \$1.60, which amount covers the postage.

First Aid in Emergencies. By ELDRIDGE L. ELIASON, A.B., M.D., Assistant Surgeon, University of Pennsylvania Hospital and Howard Hospital. Philadelphia and London: J. B. Lippincott Co.

We heartily agree with what the author states in his preface, viz., that his book, he hopes, will be "a help to humanity in general to meet and treat the ordinary emergencies that arise in everyday life." The volume is one that should be at the disposal of factory managers, boy scouts, foremen, etc., and those who are brought into close touch with injury cases, thus enabling them, in many cases, to preserve life till the surgeon arrives or the hospital is reached.

Bandaging. By A. D. WHITING, M.D., Instructor in Surgery, University of Pennsylvania, etc. Illustrated. Philadelphia and London: W. B. Saunders Company. Canadian agents: J. F. Hartz Co.

The author recommends that muslin be used by beginners, so as to "overcome some of the deterioration in the art of bandaging resulting from the too prevalent use of the gauze roller."

The book is quite profusely illustrated, by which the student grasps at a glance how the bandage is applied and how ideally it should look.

The author shows first how to make and apply the roller bandages. All the special bandages are then described, many of them being photographed. The second portion of the book deals with the tailed bandages; and the third with the various uses of the handkerchief bandages.

The book costs \$1.25, and will be found valuable to senior medical students, hospital internes and nurses.

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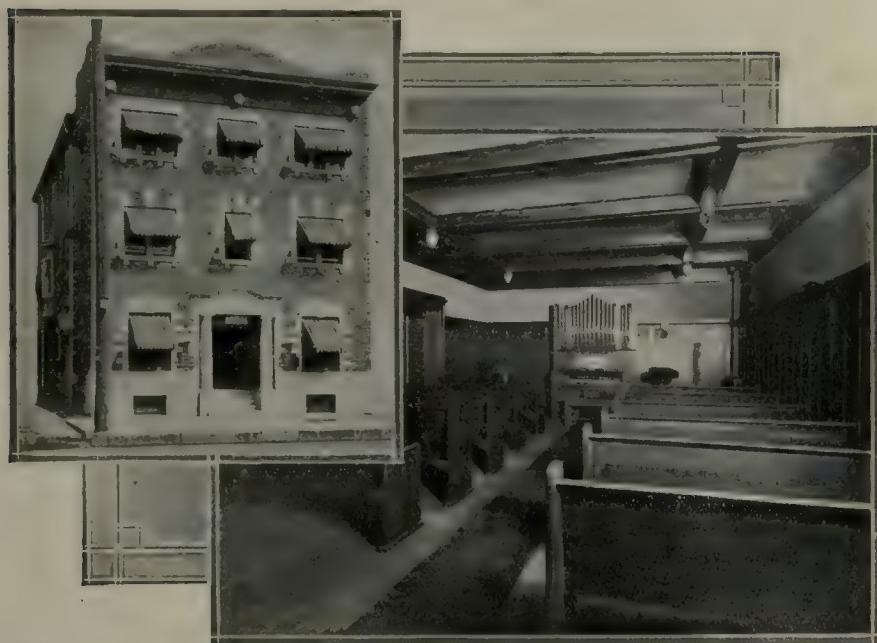
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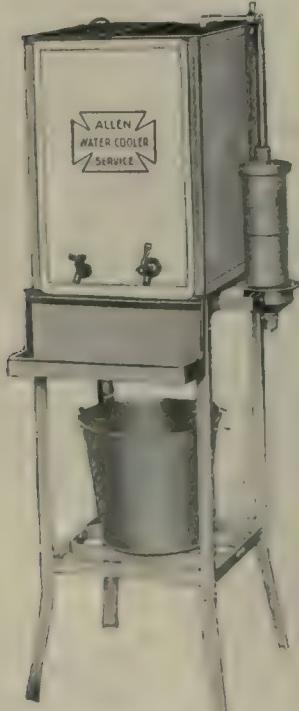


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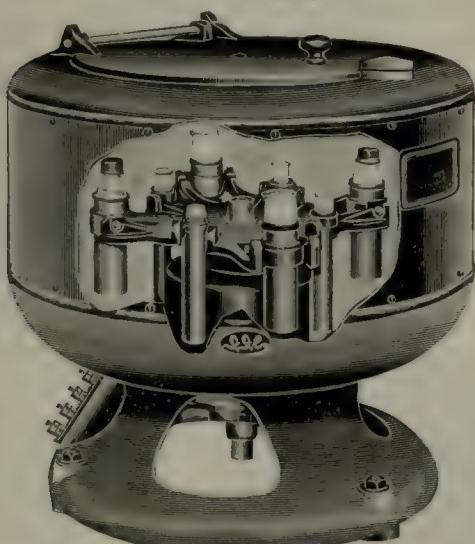
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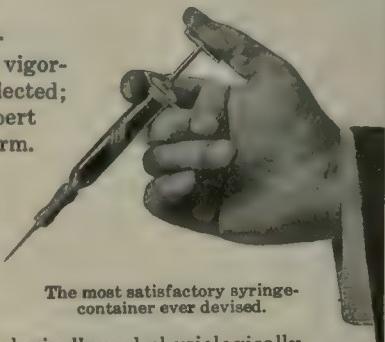
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THE HOSPITAL WORLD

Vol. IX (XX)

Toronto, April, 1916

No. 4

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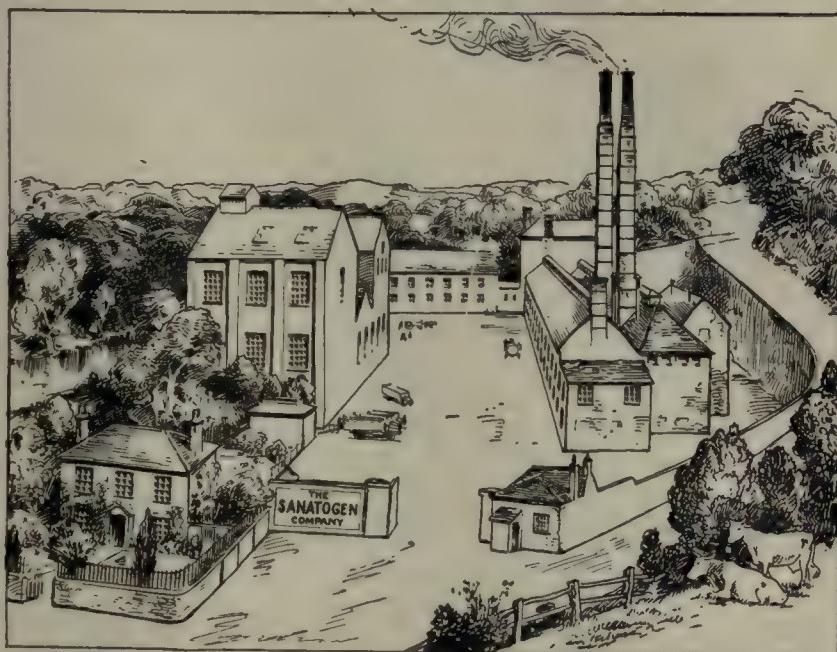
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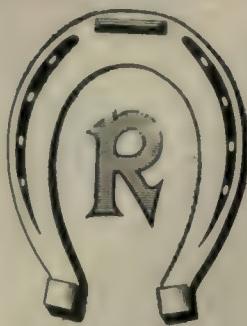
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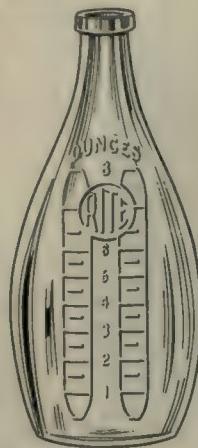
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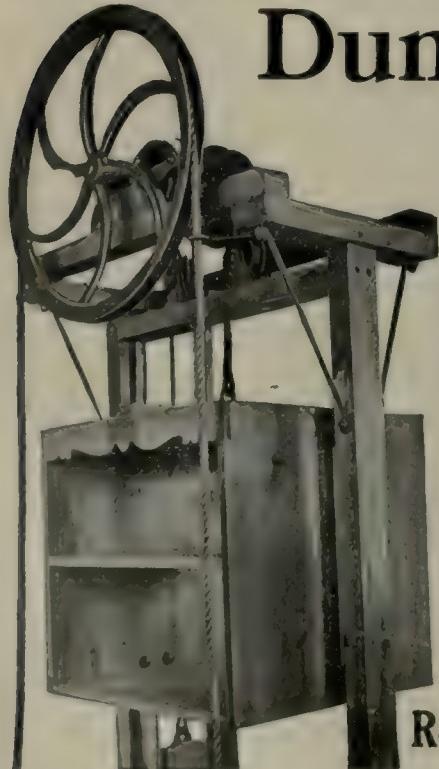
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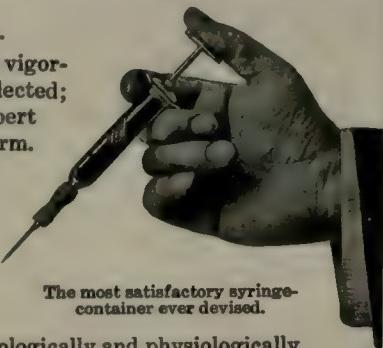
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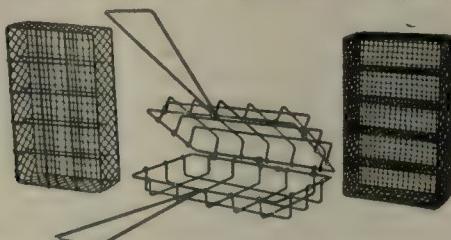


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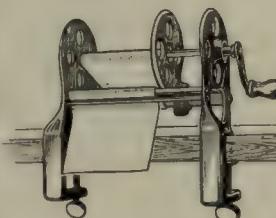
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Vol. IX.

TORONTO, APRIL, 1916

NO. 4

Editorials

HINTS ON HOSPITAL FURNITURE

IN planning a hospital every article of furniture for each separate room should be indicated on the plan at an early stage.

Only those having experience in hospital equipment realize how much of time, worry and expense is avoided by observance of this rule.

To discover when the outer and inner walls are up, and the various rooms are practically unalterable, that the essential furnishings must be crowded, incomplete or placed at disadvantage for service is one of the too frequent sad experiences of the hospital administrator.

It is not too early to begin listing the hospital furnishings together with the building of the outer walls; and the onerous task is made much lighter when all articles of furniture are drawn to scale in their proposed relative positions; the said positions being fixed, of course, by consideration of the purpose of the room.

In the working departments the equipments are to be considered from the standpoint of durability and economy in time and labor.

In ward outfitting, in addition to the above must be added a regard for aesthetic effect in as far as possible.

In the diet kitchen, for instance, every article—steam table, refrigerator, tray rack, table, sink, dish sterilizer, etc., should all be drawn in to scale in the relative positions which have been decided upon as most convenient.

In the utility room the clinic and fomentation sinks, the utensil sterilizer, the bed pan and urinal rack, the metal work-table and other needful articles should also be properly indicated.

In the private ward the lavatory, the bed, the couch, the bureau, the bedside table and chairs should all be drawn in to fit without crowding; yet give sufficient room for the medical nursing work; also with due consideration for the patient's comfort. A bureau so placed that the reflected mirror light dazzles the patient's eyes, a bed placed of necessity facing a window or in a dark corner.

Such errors are easily prevented when room furnishings are carefully placed upon the plan; yet are unavoidable when the building is once erected.

It is best to give orders for the selected furnishing at an early date in the hospital construction, so that it may be ready without rushing when required; also the hospital management may have time, not merely to select wisely but to look the order over when delivered and see that in all respects it comes up to specifications.

It emphatically pays a hospital furnishing committee to visit recently equipped institutions, as well as dealers in hospital furnishings, in order to become conversant with what is best in the line of their requirements. Having done this, and made their decision, the orders should be given promptly.

If the funds allotted for the purpose are too limited it would be better to equip partially with only absolute essential and to furnish more completely gradually rather than fully equipping with cheap stuff that remains always an eyesore and an expense.

HOSPITAL PREVENTIVE WORK

MEDICINE, in as far as it applies to life conservation, is rapidly becoming a department of State control, and in this social departure our hospitals must play an ever-increasing part.

It is interesting to review the rapid evolution of the hospital from a shut-away and shunned charity institution of a quarter-century ago to its present position as a prominent factor in social welfare. "Preventive medicine" is the slogan of the socio-medical world to-day, and it is from the hospital and its associated organizations that leadership in this modern movement is expected.

The benefits to be derived from supervision of individual health and sickness by a body of medical men working in co-operation is exemplified by work at present being carried on by the Boston Dispensary.

During the past year a special clinic called the Preventive Clinic has been held there daily for well children. To this unique clinic are brought apparently well boys and girls under twelve years who are about to be placed out in private homes by the Children's Aid Society. These children are thoroughly examined and records made of results. Where any weakness is discovered, the case is handed over to a specialist. Defects of sight and hearing are the most frequent. But any case requiring medical or surgical care passes from the status of a "well" child in the preventive sense to that of a patient for regu-

lar treatment in the children's department of the hospital.

After these "well" children are placed out in the individual homes allotted, the workers of the Children's Aid Society, who visit them at regular intervals, confer with the head of the preventive clinic if need arises, and by turning to the records of the child or children in question, the head has direct knowledge of each case, and can recall any of the children from their foster homes if necessary for further examination or treatment.

The clinic aims to provide a continuous medical history and oversight for each child, and thus give it a prospect of healthy adult years. Since April, 1915, about thirty new "well" children each month have been examined and their records taken. The clinic is a special one, carried on in connection with the usual work of the dispensary, and is of very great interest, since it is the first known organized endeavor to provide continuous medical and hygienic oversight of a number of children for a number of years. A very small percentage of the children of the well-to-do receive such close and continuous medical care as these fortunate little waifs are getting.

But this new departure is most interesting in that it suggests a possible form in which the great movement toward State Preventive medical work may be crystallized.

Original Contributions

LITTLE JOURNEYS

BY DR. JOHN N. E. BROWN,
Superintendent, Henry Ford Hospital, Detroit.

A MORNING AT "THE ROCKEFELLER."

PASSING down through the purlieus of the East Side of New York City along Sixty-sixth Street, we come to the Rockefeller Institute and Hospital, which has a commanding view on the high, dry, and rocky bank of the East River.

On a plot of some four acres one sees, looking from left to right, a power-house, animal building, laboratory building, institute building for contagious diseases, and hospital building. The hospital and institute buildings are eleven and five stories in height, respectively. The other buildings are not above one and one-half stories in height. The land and buildings represent an investment since 1901 of \$4,500,000. The institution was established by Mr. Rockefeller for "medical research, with a special reference to the prevention and the treatment of disease." The amended charter of 1908 says:

"The object of the said corporation shall be to conduct, assist and encourage investigations in the sciences and arts of hygiene, medicine and surgery, and allied subjects, in the nature and causes of disease and the methods of prevention and treatment; and to make knowledge relating to these various subjects available for the protection of the health of the public and the improved treatment of disease and injury. It shall be within the purposes of the said corporation to use any means to these ends which from time to time shall seem to it expedient, including research, publication, education, the establishment and maintenance of charitable or benevolent activities, agencies or institutions appropriate thereto and the aid of any other such activities, agencies or institutions already established or which may hereafter be established."

In the institute, problems of disease and their pathological or their physiological effects are dealt with, using to their fullest extent experimental methods. In the hospital a study is made of biological and chemical problems, particularly of some of the commoner diseases. The hospital staff comprises men who have been carefully trained along their particular line.

In the institute building are provided the necessary administrative offices, assembly-rooms and stockrooms.

One floor is devoted entirely to chemical laboratories, large and small, with a distillation room, a hydrogen sulphide room and combustion room.

Laboratories for carrying on experiments in pathology, bacteriology and proto-zoology occupy another floor. One end of this floor contains the animal-operating suite. This room is provided with a bathtub and a hot-air drying chamber, where the animals are prepared for operation. In another room in connection with this, the animals are kept under observation after the operation. Only the smaller animals, such as mice, rats, guinea pigs, rabbits and monkeys are kept in this room.

Another floor is devoted to experiments in pathology, physiology and pharmacology, and also contains the preparation and the centrifuge rooms. The larger centrifuges are stationed in the basement, where they have a perfectly solid foundation.

The south end of the fifth floor contains the department of experimental biology, also a suite of rooms for pictorial records and photographs. Near the centre are two dining-rooms, one for the clerical staff and one for the scientific staff, where a substantial meal may be obtained for a nominal sum.

The animal house contains stables for horses, sheep and goats. On the second floor the smaller animals are kept, such as cats, dogs, monkeys, mice, rats, rabbits and guinea pigs. Another room on this floor contains several large tanks in which frogs are kept. In the loft of this building hay and grain are stored.

In 1908 the institution acquired a plot of land containing about one hundred acres, at Clyde, N.J., which is used as a breeding place for animals to be used for experimental pur-

poses, and also for providing farm products, another building was established at Wood's Hole, Mass., for the Department of Experimental Pathology.

The hospital is presided over by Miss Nancy Ellicott, a graduate of Johns Hopkins Hospital. Like the institute this building is fireproof throughout, being constructed of steel, concrete and terra cotta. In the corridors terrazzo is used as a flooring, while in the wards, kitchens and laundry a small round tile is used. Hard pine is used in the smaller rooms. Painted cement floors are used in the rooms like the chemical laboratories and others subjected to rough usage.

There are three basements and eleven galleries in this building, and a housed roof. The lowest basement consists of a gallery of eleven rooms, besides toilet and bath rooms, and is used by the housemaids. These apartments overlook the East River. These girls get from their rooms a magnificent view of the river with its shipping, and bridges; of the large island with its hospital buildings, of the suburban city beyond, and of the undulating country in the distance.

The next basement above contains a large autopsy room, which adjoins the pathological laboratory and refrigerator room, a central linen room, serving room, laundry, incinerating plant, ice-making machinery, four large tanks—two for water and two for compressed air; elevator machinery—including that of two elevators, and dumb waiters which connect the kitchen with all floors; coal bunkers and several rooms for storage purposes.

The floor above has an admitting department accessible to ambulances and service through a sunken driveway. It also contains the main kitchen, store rooms, pantries, refrigerators, vegetable room, three service dining-rooms and a room which contains the incinerator chute.

The hospital is built on the double corridor plan. The first floor contains the resident doctors' quarters, dining-rooms, and admitting room. The second floor contains the nurses' quarters. The third floor contains the patients' rooms, which are small for the most part. These are provided with closets. A sitting-room is found at the east end, which overlooks the East River. Each floor has access to an enclosed fire stairs. There are also

the necessary toilet and bath rooms for the patients, work rooms for the nurses, a small chemical laboratory where routine analyses and examinations are made. The stairways are centrally located, while the elevators are a little to one side. Convenient cleaners' closets are built in one side of the corridor.

The fourth, fifth and sixth floors are like the third. The wards are located at each end of the building. They run north and south at right angles to the long axis of the building, thus being exposed to the air and light on three sides. On each side of the corridor in connection with the wards are the following: kitchen, toilet and work rooms, two isolation rooms with accommodation for one patient each. The wards are forty-eight feet long by eighteen feet wide, and contain seven beds. The beds are provided with special casters, which provision enables the nurses to easily trundle them out on the balcony. The toilet and bath rooms open directly into the wards, as do the nurses' workrooms and the routine laboratories. The doors between the wards and balconies are sliding doors. The south end of the fourth floor contains the hydro-therapeutic equipment, light and vapor baths. The corresponding space on the fifth floor is occupied by a special diet kitchen. On the sixth floor is found a constant temperature room for experiments in metabolism.

The seventh floor is devoted exclusively to laboratories—chemical, pathological and physiological.

The eighth floor contains a small operating room used for special and emergency purposes, a doctor's washroom, a closet for warming blankets, a photographic and X-ray suite, toilet and bath rooms for the patients, a storage room for mattresses (the mattresses being hung vertically), and rooms for the ventilating fans. The kitchens and laboratories are provided with hoods, and are ventilated by means of fans, as are also the flues leading from the two large fireplaces in the wards. The general wards and single rooms depend principally upon the windows and doors for ventilation.

The isolation pavilion depends upon the windows and doors for the intake of air. The ventilation is accomplished by flues running from each of the rooms to the roof, in which a current

of air is created by the means of steam pipes. These flues can be cleaned by jets of live steam. The isolation pavilion is administered as a single ward rather than a series of private rooms, glass partitions being placed between the beds. The plan of this ward is based upon the theory that the communication of diseases depends largely for transmission from one person to another by infection through direct contact. A rigid technique is imposed on physicians and nurses who have occasion to be in the ward or pass from one bed to another. The second floor of this pavilion is occupied by nurses. They get their meals here. The roof is partially sheltered, and is available for beds and as a place for the recreation of patients and nurses.

The hospital contains seventy beds, and the work at any one time is confined to selected cases that bear upon a limited number of subjects chosen for investigation. During the first year the subjects chosen were acute lobar pneumonia, acute anterior poliomyelitis (infantile paralysis), syphilis, certain studies in disturbed metabolism, and certain types of cardiac diseases. In the second year a limited study of scarlet fever was also made.

No charge is made to patients treated by the hospital.

The courteous doctor who showed us through the institution informed us that one of the types of pneumonia was responding to a vaccine manufactured from the germ which produced the disease. They had had only one death from this type of pneumonia so treated.

Of the distinguished work of Dr. Carrell and the other members of the staff in surgery we shall not speak, but refer the reader to the publications made by the institution: they are the *Journal of Experimental Medicine*, the *Journal of Biological Chemistry*, *Studies from the Rockefeller Institute for Medical Research*, and various monographs prepared by various members of the staff. These can be obtained direct from the institute upon application.

The general administrative and financial conduct of the institution as distinguished from the strictly scientific activities is delegated by the Governing Board to a manager. In the hospital the superintendent is responsible for the nursing, house-keeping and purchasing of supplies.

For the purely scientific work, the Director of Laboratories is the chief advisor to the Board of Scientific Directors, and is the ordinary means of communication with the scientific staff and the board. The hospital has likewise a medical director. The work in the other subjects is directed by the members of the institute and their assistants. Appointments to the scientific staff are made by the Board of Scientific Directors upon the recommendation of the Director of Laboratories or the Director of the Hospital. The institute grades are as follows: —Member of the Institute; Associate Member of the Institute; Associate; Assistant; Fellow and Scholar. The hospital grades are Physician to the Hospital; Assistant Physician to the Hospital; Resident Physician; Assistant Resident Physician. Appointments of the members of the institute are made without limit of time, the associates for a term of years. All other appointments are made for a term of one year. All members of the staff are paid. There is no provision made for formal teaching in the institution.

CAUSATION OF AMENTIA*

BY L. R. YELLAND, M.D.,

Physician, Hospital for Insane, Mimico; Assistant Psychiatrist,
Toronto General Hospital.

THERE seems to be an innate tendency in man to seek after a causative factor in any and every form of mental or physical enfeeblement. The sufferer almost invariably asks the reason for his misfortune, and it is surprising the comfort he derives when he is given a supposed cause. But it must be admitted that definite knowledge of the causation of amentia is very limited, and in place of facts which the scientific mind must always seek, the subject is largely involved in speculation. It is in these cases that the reflex phenomenon has been so frequently used as an explanatory means, and the most amazing reflex paths have been supposedly traced. More information has been looked for from the pathologist, but as yet little change has been observed in structures thought to be concerned. In the consideration of the causation of amentia, the nature of other mental disorders must be understood to some extent, as the cause of one is intimately associated with that of the other.

Amentia has been defined as a state of imperfect or arrested cerebral development, and on investigating its causes, influences concerned in embryonic development, as well as those affecting the brain after birth, must be inquired into. That is, the family and other personal history of those so afflicted must be ascertained as completely as possible. In the investigation of a number of these cases in the Hospital for Insane, Mimico, as well as at the Social Service Department of the Toronto General Hospital, it would appear that the main influence responsible for the imperfect condition is in the mal-development of the brain cells. However, this is difficult to demonstrate. Realizing the difficulty and the tendency to speculate in the explanation of this phenomenon, it will be my purpose in dealing with this subject to call attention to observations made on a clinical and personal study of a number of these cases.

* Read at the Academy of Medicine, Toronto.

It is generally agreed that the effects produced by inheritance and environment are the most important factors responsible for the imperfect condition of the cerebral cells, mental defect being rarely caused by injurious external factors acting alone, and in the majority of cases the cause lies in the condition of the germ plasm. The question of inheritance and environment is an important one in view of its sociological bearings. It will be interesting to quote some of the evidence tendered to the Royal Commission on the Feeble-Minded, 1908, regarding it.

Prof. Sir T. Clifford Allbutt said: "I regard feeble-mindedness (if not accidental) as always hereditary."

Doctor Henry Ashby said, "In at least seventy-five per cent. of the children with amentia that I have examined there was a strong probability that the amentia was hereditary and primary." Dr. Ashby further stated that he had observed no special tendency in the children of alcoholics, or of women who suffer privation during pregnancy, or in those children who live in unfavorable conditions subsequent to birth, to develop amentia.

Dr. Bedford Pierce stated that he considered heredity to be by far the most important factor, and relatively more important in mental enfeeblement than in insanity.

Dr. Bevan Lewis said, "There is not the least doubt of it in my mind; I look upon feeble-mindedness as a germinal variation."

In reference to this matter psychiatrists in this district have made the following statements:—

Dr. N. H. Beemer said: "Heredity plays a more important part in the production of amentia than probably all the other causes combined."

Dr. J. A. Rollins, associated with the Orillia Institute for three years, said, "Heredity is responsible for seventy-five per cent. of aments."

Dr. C. K. Clarke said, "Not all, but a great many, cases of amentia are hereditary." The Social Service Department established by Dr. Clarke at the Toronto General Hospital has done excellent work in the investigation of the social con-

ditions and the examination of the feeble-minded, a large number of which cases have already been examined.

In a majority of cases where parents of mentally defective children appeared at the Psychiatric Clinic, these parents proved to be of equal interest from a psychiatric point of view to the children brought there for advice.

Taking it for granted that environment is an important factor, from my viewpoint it is a resultant of heredity just as alcoholism is of mental disease.

In the careful investigation of family histories, various disorders in the members of the family present themselves so frequently that one is led to believe that these factors are capable of producing a variation in the germ plasm. Some of these cases will give a history of alcoholism, others syphilis, others still tuberculosis, and a majority of them show a neuropathic inheritance. Other disorders, as paralysis, hysteria, chorea and the drug habit, are found through various family histories, as well as rheumatism, gout, kidney disease, cancer, heart disease and goitre. The nature of the germinial defect is peculiar. It is interesting to note that the ancestors of these mentally afflicted individuals suffer from such diseases as epilepsy, insanity and dementia, and not from a similar mental disorder. However, those occurring most frequently are the neuropathic diathesis, alcoholism, tuberculosis and syphilis.

It is agreed by all who have studied this question that the most frequent associating factor concerned in the causation of amentia is the neuropathic diathesis. This manifests itself by the repeated occurrence of such neuropathological states as amentia, insanity, dementia, epilepsy, paralysis, or various neuroses. A glance at the parents of these unfortunate children shows at once a pronounced neuropathic and defective stock. Unquestioned statistical proof of these statements may be obtained by anyone desiring them from the records available at the local institutions. The later conclusions of modern observers now seem to be that even epileptics begin their lives under a defective mental handicap, and while many become demented after a series of seizures, others have never attained to any degree of intellectual development. Some time ago I

wrote a letter to the nearest relative of nineteen of these epileptic patients at Mimico; among other things I asked for "inheritance." There were ten answers to my letters, eight giving positive histories of hereditary taint. Nine of these letters were not replied to. This, by the way, shows the reluctance evinced by some people to admit the presence of mental unsoundness in the family, and consequently proves to be most disconcerting to the investigator. I believe, if the Lange* test is to have a place in the scientific world, it will be in connection with these cases, eight out of nine of my cases producing a bleaching of the colloidal gold.

Many cases will show a history of alcoholism; in at least fifty per cent. of cases will there be found such a history. It is only fair, however, to state that in a great majority of these there is likely a definite neuropathic predisposition also, which expresses itself in the alcoholic habit. Alcohol may act in two ways: it may first of all so impair the germ plasm as to cause pathological variation; or it may, in the second place, have a direct effect upon the embryo after fertilization has occurred. Alcohol soon appears in the blood after digestion, and it has been shown by experiments that it has a most baneful effect on growing protoplasm. It follows that the systematic abuse of alcohol by a pregnant woman may be attended with decidedly injurious consequences to the offspring.

In dealing with alcoholism and other toxic agencies, as tuberculosis, syphilis, lead, etc., unless the father alone has been affected, it is not always possible to say whether the effect is upon the germ plasm or upon the growing embryo.

It would seem, though, that the action of alcohol is more often contributory than directly causal, this in view of the fact that it is often accompanied by a history of insanity, epilepsy or other neuropathic conditions. It should be remembered, however, that exaggerated statements are commonly made by biased persons regarding it.

Tuberculosis, though occurring quite frequently in families of feeble-minded children, is not likely to be a direct and sole

* Examined by Dr. G. A. Ramsey, London, Ont.

cause of amentia, but possibly, like alcoholism, it has an important indirect and possibly also a contributory influence.

The investigation of case books would lead to the conclusion that syphilis is not a frequent cause of amentia, a very small percentage in my records giving such a history. The history, however, is quite unreliable, and proves to be misleading. It would be expected that the Wassermann reaction would supply far more reliable evidence of syphilis than would the investigation of the family history. The results vary from one per cent. to twenty-one per cent. positive. The result of fluids sent to Dr. Detwiler was two per cent. Syphilis may be capable of producing an impairment of the germ cell in consequence of which a condition of primary amentia results, which is probably indistinguishable from primary amentia in general, or which may possess hitherto unrecognized particular features. It is interesting to observe that in the majority of patients in whom syphilis is present, other factors will be found in addition, generally a neuropathic inheritance. The syphilitic poison seems to have a predilection for finding out the weak spot, and if there be a predisposition to nervous weakness, the offspring of syphilitic parents may be mentally deficient. In the absence of such it will possibly escape.

The real nature of the inheritance underlying this condition is difficult to understand, in view of the fact that the defect transmitted to the offspring is not a similar one. For instance, it is not uncommon for the ancestors of these aments to be epileptics. Heredity has been defined by Professor J. A. Thompson as the genetic relation between successive generations. The medium of the relationship must be the germ cell, which appears to hand on certain tendencies to development. Although experiments have been made on plants and animals, and have proven useful in horticulture, agriculture and stock breeding, experiments are wanting in the human. This, therefore, leaves us to theorize and speculate. Researches made by Mendel and others have shown that it is highly probable that the germ cell contains within it a series of forces or determinants which direct and control the development of each separate organ and tissue of the body. The influence, there-

fore, exerted by these controlling forces is possibly quite considerable. Tredgold says, "Amentia must be regarded not as due to the absence or suppression of some specific germ determinant, but as resulting from a diminished germinal vitality in consequence of which development tends to be incomplete."

Other factors, such as consanguinity and age of parents, must also be considered as they will be observed in the study of the family histories.

Consanguinity, no doubt, is quite unimportant; instances are not wanting in which inter-marriage has taken place for many generations without the slightest untoward result. For a better understanding of this subject it would be necessary to refer to the "laws of similarity and dissimilarity of parents," also to some recent literature on Eugenics. Cases have been reported, however, in which the stock of intermarried cousins was defective. The question that would first come to my mind is, does such a desire betray a defect?

There are reasons for thinking that the age of the parents at conception is not without influence upon the vitality of the child. Children of fathers below twenty and above forty are said to be weaker than when the fathers are between these ages. Also the children of mothers over forty are said to be weaker than those born when the mother is below this age. There are few statistics to prove this, and it is possibly quite unimportant.

Lastly, factors acting directly upon the offspring will have to be considered. These factors are before, during, and after birth.

Those acting before birth are mostly referable to some unhealthy mental or physical condition of the mother during pregnancy, although an actual injury to the fetus may also occur during this time.

Some time ago a boy of eight was examined at the outdoor clinic of the Toronto General Hospital. The mother said he masturbated, taught other children the habit, and acted in an abnormally indecent manner towards his little sister of three. He defecated on the carpets at home, would bite anyone who interfered with or teased him; played truant from school;

would bite and spit at his comrades; bad tempered, dishonest, immodest, untruthful and quarrelsome; could not be trusted with money or sent on errands. The whereabouts of the father is not known; the mother was taken down a lane, drugged and assaulted, this abnormal congenital pervert being the result.

During birth they chiefly relate to the various abnormalities attending labor. After birth the factors are either traumatic, toxic, convulsive, or some disturbance profoundly influencing nutrition. A history of one or more of these factors can be elicited in a considerable number of cases of amentia. The effect, however, in a majority of cases is simply a contributory one, and the history of the neuropathic taint can usually be traced.

* THE GERMAN-BULGARIAN INVASION

BY DR. HARRIET COCKBURN, TORONTO.

DR. HARRIET COCKBURN was with the Stobart Hospital Unit (British Serbian Relief Fund), at Lapovo, on the main line between Belgrade and Nish and tells her story of the German-Bulgarian invasion:

"From towards the end of September, German aeroplanes delighted in crossing the Danube in the dark and treating us to an air raid every morning. We would see these enemy air-ships flying along to Kragujevatz military headquarters, and then in a few minutes, it was grand to hear the reception they got from the guns at the Kragujevatz arsenal. On their return, the German aeroplanes always dropped a few bombs round the Lapovo Station and on us incidentally.

The Germans stormed Belgrade about October 6th, having timed well their attack, no longer any danger from typhus to the invading army, and the Serbians engaged with the treacherous Bulgarians. Everyone knows how, in spite of their heroic resistance against the most terrible odds, the often-tried, brave little Serbian army had to gradually give way before the German

* Written especially for "The Hospital World."

advance. Immeasurably sad it was to watch train loads of poor refugees, driven from their homes and utterly destitute, as they escaped down the line, on open trucks, any hour night and day. On came the cannons nearer and nearer till at last, October 24th, midnight, our turn came to leave Lapovo, the Germans taking possession next day. Ourselves homeless, we left our wounded in the hospitals at Nish, which soon after fell into the hands of the Bulgarians. By October 28th, thousands of wounded soldiers and refugees were driven as far as Kralyvo. There was not sufficient shelter for everyone and many thronged the streets without a place to lay their heads. The approaching cannons of the ruthless invaders soon dislodged us from there, and never shall I forget the pathetic sights over the Serbian hills to Raska and on to Mitrovitsa, six days' march, and sleeping in the open. All went the same weary road, splashing through the rain and the mud, the prisoners of war, the wounded Serbian soldiers and hundreds of poor young recruits. It was pitiful to see the latter, mere children, only seventeen years old, poorly clad, many without shoes, here and there one shouldering a rifle, all being hurried along.

At Raska and Mitrovitsa were gathered thousands of wounded Serbian soldiers, fine, manly-looking fellows who, although attenuated by terrible suffering and fatigue, still did not lack one jot of the brave spirit and bearing of their race. Dressing stations were hastily improvised at Kralyvo, Raska and Mitrovitsa. Here famine stared us in the face, the shops were closed and rations dealt out sparingly by the authorities. Equipment lost, no chance for work and feeling that what we ate meant less for those who must remain, decided many of us to hasten out of the country. We first tried to get out by Monastir and Salonique; but after toiling as far as Prisren, we found the route blocked by the Bulgarians, so then for over the Montenegrin mountains and through Albania.

The journey on to Podgorizza and hence to Scutari was done practically on foot, through snow and blizzards, sleeping in stables or in the open, and without proper food. Hundreds, perhaps thousands, of the very young, the weak and the old must have perished from hunger and exposure. The cruelty of it! In the harbor at San Giovanni di Medua we saw eight food

ships, which were sunk by the Austrians one beautiful Sunday morning before the eyes of the starving Serbians and Montenegrins.

The party I was with (under the kind protection of Sir Ralph Paget, British Commissioner in Serbia), were rescued by an armed Italian boat which had brought food into Medua, and was escorted by two cruisers. Others had a further dreadful journey to Durazzo and were picked up there. These Serbian refugees, rescued from different points on the Adriatic and from Salonique were taken to Corsica, Corfu, Italy and France, and it is now one of the missions of the Serbian Relief Fund to succour these people with money, food and clothing. No one who realizes the destitution of the brave Serbians and Montenegrins can fail to appreciate the blessings of Canada. As the young Serbian I brought with me never tires of remarking: "Serbia, Montenegro, Albania, no good, no bread; Canada, good; Canada, bread."

Selected Articles

THE HOSPITAL TRUSTEE*

BY ARTHUR RYERSON.

One-time President of St. Luke's Hospital, Chicago, in 1898.

The modern hospital somewhat resembles the modern battleship in being a complex and highly-developed outcome of modern science. Like the battleship, too, it possesses dangers and possibilities of dangers unknown to similar forms of human skill or benevolence.

For the purpose of illustrating this let me briefly enumerate some of the functions of the modern hospital. First of all, it is a charitable institution pure and simple; on the other hand, as to its pay patients, it is an invalids' hotel. Again, as to its doctors and internes, it is a medical school, and as to the education of its nurses it is a woman's college. These are four very important and very different objects. But beside these a hospital must be as to its dispensary, a drug business, as to its ambulance service, a humane society, as to its endowment a legal trust, and last but not least, as to the general demands upon it, a diplomatic bureau.

This enumeration is far from being complete, but is sufficient for our purpose, which is to demonstrate that the proper government of such an institution is one of the most difficult and trying tasks that the mind of man can conceive, and one quite on a par with the intricate problems of political or business life. Well may any man deem it an undertaking worthy of his best powers.

Now, the growth of the modern hospital theory has been progressive and comparatively recent. Beginning with the early days of Christianity, the hospitals gradually emerged from "the hostel," the house by the roadside, where the sick

* Published in "Hospital Life," Chicago, eighteen years ago.

and weary might find refuge and a roof, down through the "hotels Dieu" of the latter Middle Ages, founded in charity but often reeking with contagion, to our own time with its science and scientific charity. It is but a few years since the idea of hospital service was inseparable from that of pauperization. Hospitals were regarded as the last resort of the poor, who, in entering them, abandoned all hope, even to their lifeless bodies. I have myself been asked by intelligent people if all free patients' bodies were not cut up, and it was the tender hearted but witty president of a Chicago hospital who, on being asked by a lady, "If they really did burn babies at his hospital," couldn't help replying, "Yes, madam, we find them cheaper than coal." But such ignorant ideas are fast disappearing. The hospital is being recognized as one of the great agencies and schools of modern science and progress, and also one of the greatest organized means of modern charity, to be used as all charities should be used, in such a way as to elevate the community and not to degrade or pauperize it. In this regard we have, in America, advanced beyond any other nation. We have come to realize that indiscriminate pauperizing charity does more harm than good, and that the man or woman who obtains free hospital service when not entitled to it has not only put himself on the level of a street beggar, but has done the community much injury.

Turning to the medical or scientific side of the hospital, we have come to see that while hospitals exist partially for the increased opportunities which they create for medical study and advancement, their first and greatest object is the relief and care of the sick. Advanced science and advanced charity go hand in hand. Such considerations must be in the mind of every one who takes upon himself the sacred responsibility of hospital management either as a trustee or an official.

It will be noticed that I have used the masculine gender in speaking of the hospital trustee. There are reasons, which hardly could be enumerated here, why a general hospital of much size demands men for its trustees and chief executive officers. Smaller hospitals requiring less financial support, and involving fewer relations with things medical, may be conducted

by boards of women, especially for women and children alone. Granted then that a board of trustees of men are required to assume such obligations, where are they to be found? I answer in every community in our land. There is no one so busy, no one so rich, that he does not owe some time to such work as this. The obligation even exceeds that of giving money. This may be a hard lesson to preach to a busy community, but it none the less is a necessary one. Wrong circumstances often debar the pick of our men from political life. They will not enter into the shambles which seem too frequently the synonym of polities. But the way is open for such men to be of great use to the community in some such fiduciary capacity as has been pointed out.

Nor need the duties of a trustee be necessarily too requiring for the ordinary man. A monthly meeting held usually at a late hour in the afternoon, ought to suffice for the full board, and this might be omitted in July and August. While committee work is exceedingly important, it can easily be arranged to suit the hours of even those whose time is least their own. It is not lack of time but of inclination that stands in the way, as our club and our social engagements could tell.

Coming now to details, the Board of Trustees should, for a large hospital, number from twenty to thirty, with a reasonable provision for a quorum. As to committees, there should be an Executive Committee, not as so often happens, to take the Board's place, but to act for it in emergencies. The other committees will naturally group themselves in each department needing oversight. Let them as a rule be many in number, but small in size, and let the inspection rotate, but not oftener than once in three months. Every trustee on inspection duty should be supplied with a copy of "Suggestions to Hospital Visitors," by Drs. Billings and Hurd. No trustees, as such, should ever give actual orders in the hospital. That should always be reserved for the Executive Department, whose action may be based upon his report. This is analogous to the discipline of a ship, or in an army, and is most important for that discipline.

We next come to the relations of the trustees with the Medical Board. This is a matter of great importance. At the

International Congress of Charities, in 1893, the Hospital Section discussed it fully, and while some extraordinary views were expressed, the conclusion reached was undoubtedly correct. It was this—the trustees must be the supreme governing body of the hospital, and as such must appoint the medical staff. This is a weighty responsibility, and one in which the nominating power ought in the first instance to rest jointly on the trustees and staff itself. While the trustees must be left free to follow or disregard such nominations, they should only do the latter for very good reasons. The medical staff should be appointed during good behavior, and not for a term, and while the power of removal must rest with the trustees, it should be guarded by a two-third vote, and of course by the most careful and judicious action on the part of each trustee. Then, having carefully selected the Medical Board, it should be left supreme in all matters calling for expert opinion or action. At the Congress just referred to a venerable trustee of one of our eastern hospitals stated that in his opinion the Board of Trustees should interfere with the medical staff in their treatment of typhoid fever if they thought best to do so. Nothing more irrational than this can possibly be imagined, and no sensible person would conduct his own affairs upon such a principle for an instant.

This general rule that has just been laid down, covers pretty well all the relations of the Board of Trustees to the medical staff. Of the duties of the staff the scope of this paper admits no notice. The executive officer of the Board of Trustees will naturally be its president, through whom the directions of the Board pass to the working executive, who is usually the superintendent. But it is a prodigious mistake to throw too much upon the president, either of power or responsibility. Such a course makes a one-man institution, which consequently has few friends. The trustees get to thinking that they can leave everything to their president and soon lose their own interest, and the hospital suffers.

The superintendent may be a clergyman or a doctor or a layman, but he *must* be a remarkable man. He should be supreme over everyone in the house, including internes and nurses. As

to the internes his authority is of course one of discipline, for in matters medical they must owe their responsibility to the attending staff. As to the nurses, their discipline is through the Chief Nurse, who, under the superintendent, represents the hospital authority over them. The relation of these officers and also the powers of the superintendent generally ought to be carefully marked out by rule. Generally speaking, the time spent in drawing up good rules is well employed. The superintendent is expected to keep the peace with every one *in* the hospital, and make peace with every one *outside* of it; and this is no sinecure, when the hospital is full and running behind financially, and a dozen influential people are demanding admission for free patients. Whatever he does both he and the hospital are quite sure of some unreasonable criticism. He is expected to judge whether an applicant is worthy of free admission, or of half or whatever rate requested, and amid professional sensitiveness and jealousy he is expected to steer a perfectly faultless course always. He sometimes fails—he would not be human if he did not; and for him, for trustees, and hospital management generally, it would perhaps be well to reserve a little of that charity which covers a multitude of failings as well as sins.

It is hardly possible, within the limits of such a paper as the present, to do more than allude to the various departments of hospital economies which ultimately must find their way before the Board of Trustees. They may be divided into two: Questions of support, and questions of administration. Roughly speaking, the support of any hospital is made up of: first, earnings; second, donations, and third, interest upon endowment. Each of these requires especial attention and very different management; and it would perhaps be as well for each to be in charge of a special committee.

The item of donations is, of course, more or less uncertain, and, therefore, in computing income for a basis of expenditure, the only safe course is to get the average of donations for a long period and keep well within it. I am aware that it is a common saying that every good hospital should show an annual deficit, and I have seen reports of hospitals in New York which showed

deficits of nearly \$90,000 year after year. But to say nothing of the anxiety of the managers and risk to creditors involved in this, I am inclined to think that in the long run the institution would prosper more by a more conservative course. Every hospital must and should depend to some extent upon pure charity; and in the drawing out of this the energy of the trustees and friends of the institution must be an important factor. This is an equation which the management must decide.

The suggestion of income from endowment is merely one of good business management on the part of the Trust Fund Committee of the Board of Trustees. All endowments should be held by such a committee, each endowment invested separately, and only the income paid out to the Treasurer. The latter officer's functions are to receive and collect all income and to pay all authorized expenditures. It is important to clearly define this at the start.

There remains only the item of earnings from pay patients, but this is by far the most difficult problem of hospital management. Almost all existing hospitals have had to approach this question from the wrong end. They were begun as free or charity hospitals, and they have found pay patients a necessity. It would be better to begin our hospitals as pay institutions and to gradually widen them as charities, according as our means and our knowledge increase. But, dealing with things as they are, let us remember that a pay system graduated to the needs of the patient is not only the noblest of charities, but one of the most rational systems of bettering human nature that we know of. Our hospitals have many opportunities to do good to absolutely needy cases, but infinitely more opportunities to help those whose means do not admit of really good medical care and nursing.

The county-and city hospitals are open to the former class but not to the latter, and it is the boast of our American hospitals on private foundations that to them this working out of a graduated pay system is due. The full-pay patients, including those who pay higher prices for private rooms, are a simpler proposition. They should show a profit that will go to make up the losses in other directions. It is to them only also that the

medical staff can look for any remuneration of their services. The foregoing sums up simply a few of the problems of support likely to come before a Board of Hospital Trustees.

Turning now to the side of the administration, there are very many questions likely to be presented to the trustees through their committees, or by the superintendent, touching matters of discipline or expenditure. As has been said, it will be usually found convenient to have these various matters first passed upon by an appropriate committee. There should be a committee on the training school for nurses, and another on employees and expenditure in general; another on earnings; also committees on audit and legal matters, medical board and dispensary, and any other matters as needed. The Executive Committee and that on Trust Funds have already been mentioned. While occasional matters may come before the Board, not admitting of delay, of reference to a committee, this is not often the case, and the well considered report of a committee not only secures by its action but interests more of the trustees as well.

In conclusion it may be said that the guiding principle which governs every act of the trustees collectively or individually should be conscientious faithful performance of duty. With such a rule the results will never be doubtful, and in the spirit which actuates it the subject may be safely left to all interested in its fulfilment.

HOSPITAL PRESENTED BY COL. GOODERHAM OF TORONTO

THE Daughters of the Empire Canadian Red Cross Hospital for officers, presented by Col. Albert Gooderham, is splendidly situated in a large private mansion overlooking Hyde Park, London, England. It will accommodate some thirty Canadian patients. The premises have been cleaned and painted and the hospital was opened late in January.

Hospital Notes

THE ONTARIO BASE HOSPITAL, ORPINGTON

THE Hospital at Orpington was duly opened on Saturday, February 19th, by Bonar Law, Colonial Secretary. Col. (Dr.) A. E. Ross, C.M.G., M.P.P. (Kingston, Ont.), who has been on the Western Front for some months past is officer in command, with Lieut.-Col. Irving H. Cameron, as Chief of the Surgical Staff, and Lieut.-Col. Graham Chambers, recently of the University Base Hospital, Saloniki, as Chief of the Medical Staff. Sir William Osler will be Consulting Physician, and Lieut.-Col. Donald Armour will be Consulting Surgeon. Major George Badgerow (who years ago practised on John Street, Toronto), will be Consulting Specialist.

It will be seen, therefore, that all of the chief officers are sons of Ontario, even though several of them for some years past have been following their profession in England. The thirty-two medical men from Ontario, along with the eighty nurses, reached England about March 10th. The Hospital accommodates 1,040 patients and has been built on the hut system. The site is an ideal one, being near London, with good railway accommodation from the principal ports, where the wounded are customarily landed. Col. (Dr.) Pyne, who has been working very hard in connection with the Hospital and to whom a great deal of credit is due, expects to return to Canada within the next few weeks' time.

Col. Ross is a Member of the Ontario Legislature, and hails from Kingston. He was born in Cobden in 1870, and is Professor in the Medical Department of Queen's University. He was Mayor of Kingston during 1908 and enlisted as a private for service during the South African war. He is a Lieutenant-Colonel in the Army Medical Corps, and volunteered for service when the present war began.

Lieut.-Colonel Irving Heward Cameron is too well known to the Profession to need any introduction. Mr. Cameron is a son of the late Chief Justice Sir Matthew Brooks Cameron,

and is one of Canada's most distinguished practitioners. Mr. Cameron is an F.R.C.S. of London, F.R.C.S. of Edinburgh, LL.D. University of Edinburgh, was President of the Canadian Medical Association in 1898, former President of the Toronto Branch of the British Medical Association, as also a member of several British, French and American Academies.

Lieut.-Col. Donald Armour was born at Cobourg in 1869, and is a son of the late Chief Justice Armour. He was educated at Toronto University and the University College, London, holding the degrees M.R.C.P. London and F.R.C.S. London. He was a former House Surgeon at Toronto General Hospital.

Lieut.-Col. Graham Chambers was born in Oxford County in 1865, and received his education at Toronto and Trinity Universities, where he secured the degrees of B.A. and M.B. He is one of the Chiefs in the Medical Service at Toronto General Hospital, Associate Professor of Clinical Medicine at the University of Toronto and Professor of Chemistry and Toxicology at the Ontario College of Pharmacy.

Major George Badgerow was born in Toronto and graduated here. He received the degree of L.R.C.P. London in 1893, and M.R.C.S. England in 1903. He at one time practiced on John Street, but for some years has been Senior House Surgeon in the Golden Square Hospital, London.

MORE DOCTORS NEEDED

TORONTO Military District has been asked to supply more doctors for service with the Royal Army Medical Corps. The request came through the Director-General of Medical Services at Ottawa. All applicants must be fully qualified medical practitioners of Ontario not over 40, physically fit, and must apply through Lieut.-Col. W. F. Marlow, A.D.M.S., Toronto. If their qualifications are suitable they will be recommended to Ottawa for appointment. Those selected must join the C.A.M.C. before being temporarily transferred to the R.A.M.C. The government will allow \$150 for uniform and \$35 for kit. The doctors will have rank of lieutenant in the R.A.M.C. and receive \$6 a day. At the end of the war each will receive a gratuity of \$300.

Book Reviews

Nitro by Hypo. A Pep-tonized Tonic for the Physician. By EDWIN P. HAWORTH, Superintendent of the Willows Maternity Sanitarium. Kansas City: The Willows Magazine Company.

This book consists of a series of articles that have from time to time appeared in *The Willows Magazine*. They are most entertaining, and we know of no better way of cheering up after a heavy day's work than for the depressed practitioner to spend half an hour perusing its pages. Do it. You will enjoy the time spent, and it will assist you to cheer up somebody else.

The Social Emergency. Studies in Sex Hygiene and Morals. Edited by WILLIAM TRUFANT FOSTER. Boston, New York and Chicago: Houghton, Mifflin Company.

This little book of 220 pages is a symposium on sex hygiene, with an introduction by Charles W. Eliot. The editor contributes a chapter on "The Social Emergency," which he says is a result of the pitiless campaign of publicity suddenly following the generations of silence on this most important question. Mr. Trufant Foster adds a second chapter in which he opens discussion on the various phases of the subject—medical, economic, legal, educational, moral and religious.

Dr. William House, of the Executive Committee of the Oregon Social Hygienic Society, deals with the physiological aspects of the question. He quotes the declaration of the leading medical authorities in America, who have pronounced that continence has not been shown to be detrimental to health or virility, that there is no evidence of its being inconsistent with the highest physical, mental and moral efficiency, and that it offers the only sure reliance for sexual health outside of marriage.

Dr. Andrew C. Smith writes on the medical phases of the social emergency, in which he portrays the terrible ravages of

gonorrhea and syphilis. Doctor Smith maintains that when clearly made aware of the simple sex principles, and convinced that it is unmanly and depraved to consider them vulgarly, the manly boy will not become a masturbator or a frequenter of bawdy houses and a victim of these venereal diseases; nor will he become a moral assassin—a seducer of girls.

The economic phases of the question are discussed by A. E. Wood. Of some 65,000 women who are adrift (self-supporting) in seven American cities surveyed, the majority are receiving less than the minimum cost of a decent living—"perilously defenseless young women." In the Illinois State Senate vice investigation, fifty girls in one day testified under oath, forty-five of whom said that their downfall had been due to the lack of money. Here is a wide field for voluntary philanthropic endeavor, pending the necessary machinery for suitable legislative enactments to deal with the minimum wage question.

The recreational phases of the question are presented by L. W. Weir, in which the benefits of playgrounds and recreations in general are considered.

The educational phases are presented in a sensible way by E. O. Sisson, in which is pointed out the role the parents, the teachers, the doctors and the clergy may play.

The moral and religious phase comes next, following which is a bibliography.

Bacteriology for Nurses. By HARRY W. CAREY, M.D.

This practical book is well bound and printed by the F. A. Davis Co., Philadelphia. Price, \$1.00 net. It contains, besides the text on bacteriology, a useful glossary and a chapter on the proper way that nurses should collect specimens. There is no disease of modern times proceeding from bacteria which is not concisely but simply discussed in terms which every nurse should understand, from the causes to the methods of prophylaxis and disinfection. The book is written not so much to make the nurse a useful drudge while under the control of her hospital, as to place her in direct, intelligent contact with the business of the world at large. Few enough pupils or head nurses either read a daily paper, but these interesting lectures contain

all the information needed by anyone who is not trying to be a doctor of science.

American Pocket Medical Dictionary. Edited by W. A. NEWMAN DORLAND, A.M., M.D., F.A.C.S. Containing the pronunciation and definition of all the principal terms used in medicine and the kindred sciences, including dentistry, veterinary medicine, nursing, etc., with over sixty extensive tables. Ninth edition, revised and enlarged. Philadelphia and London: W. B. Saunders Company, 1915. Canadian agents: J. F. Hartz Co., Toronto.

This beautiful little gilt-edged, limp-leathered volume is sold at \$1.25, and will be found a very useful volume for the various people for whom it was prepared.

Nursing in the Acute Infectious Fevers. By GEORGE P. PAUL, M.D. Third edition, thoroughly revised. Philadelphia and London: W. B. Saunders Company, 1916. Cloth, \$1.50 net. Agents: J. F. Hartz Co., Toronto.

Doctor Paul has laid particular stress on the care and management of each disease, as related to the duties of the nurse. The first portion of the book discusses the general aspects of fever; the second, each of the acute infectious fevers as to their cause, signs and symptoms, course, prognosis, care and management; the third, with practical procedures and information necessary in the management of the foregoing diseases.

The chapter on diet includes some sensible recipes. A chapter is devoted to child hygiene. Part III is devoted to a brief discussion of immunity, antitoxines, vaccines, bacteria and bacilli; examination of urine; poisons; giving of enemata, antisepsics and disinfection; concluding with chapters on abbreviations, weights, measures and selected formulas.

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Coffee as a Beverage

WHILE coffee is the most popular table beverage in the world, it is doubtful if many of its drinkers know anything about coffee except that it is a delicious drink. To a large majority of people, a few words relative to the origin, growth and manufacture of what they know only as a steaming cup of good cheer would be of considerable interest.

In the first place coffee was discovered in the far East about the year 1300, and from that date it gradually spread until by the seventeenth century it was known throughout Central and Southern Europe. It became so popular, particularly in France and England, who were at that time changing the map of the world, that it is not at all strange that it should rapidly spread all over the known world.

A coffee plant was presented to Louis XIV of France as a novelty. It flourished; a cutting from it was sent and planted in America, and from this plant has sprung the vast plantations now flourishing throughout South America.



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When they reach the manufacturer, he in turn puts them through several cleaning processes, which remove foreign material, such as small stones, etc., separates large and small and broken berries. The coffee then passes along to the roasting ovens, which consist of perforated steel cylinders, rapidly revolving over a red hot coal fire.

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From this brief résumé, you will see that the coffee from which your morning cup was made, passed through a more elaborate process than you may have imagined.

For the foregoing facts we are much indebted to Chase & Sanborn, Montreal, the well-known coffee packers.

The Chase Hospital Doll

By referring to another page of this issue of THE HOSPITAL WORLD, hospital superintendents will notice the announcement regarding the Chase Hospital Doll. As the manufacturer very truly states, "it is to the hospital training school for nurses what the laboratory is to the medical student." In fact, such a figure is indispensable in the training of a nurse, and its merits should be looked into at once by institutions that so far have not invested.

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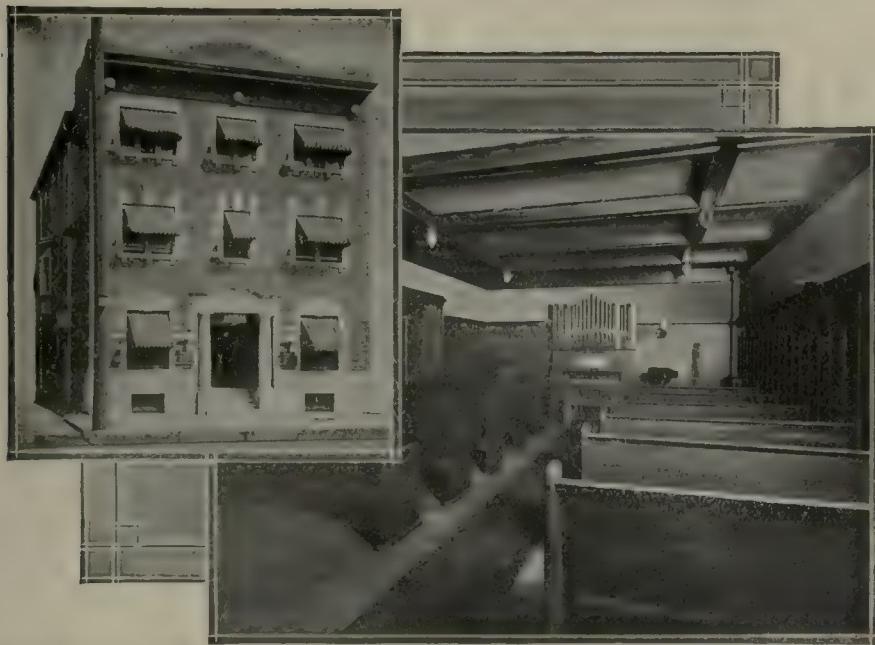
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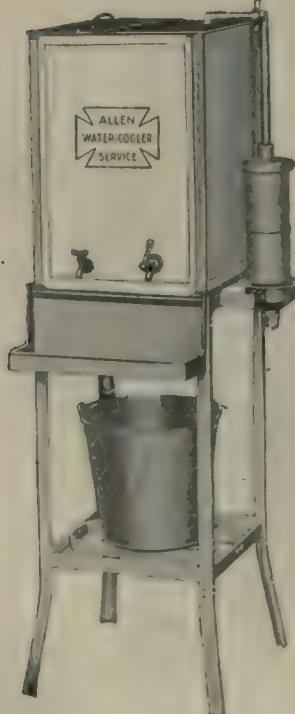


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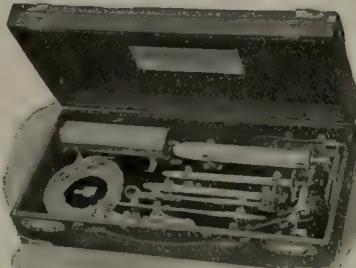
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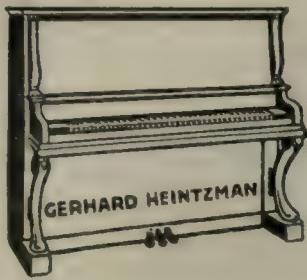
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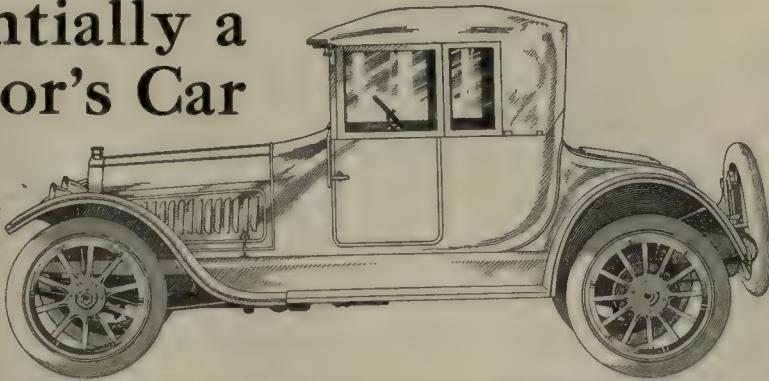
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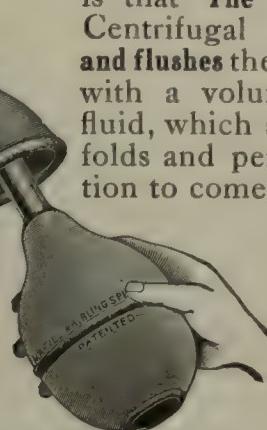
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THE HOSPITAL WORLD

Vol. IX (XX)

Toronto, May, 1916

No. 5

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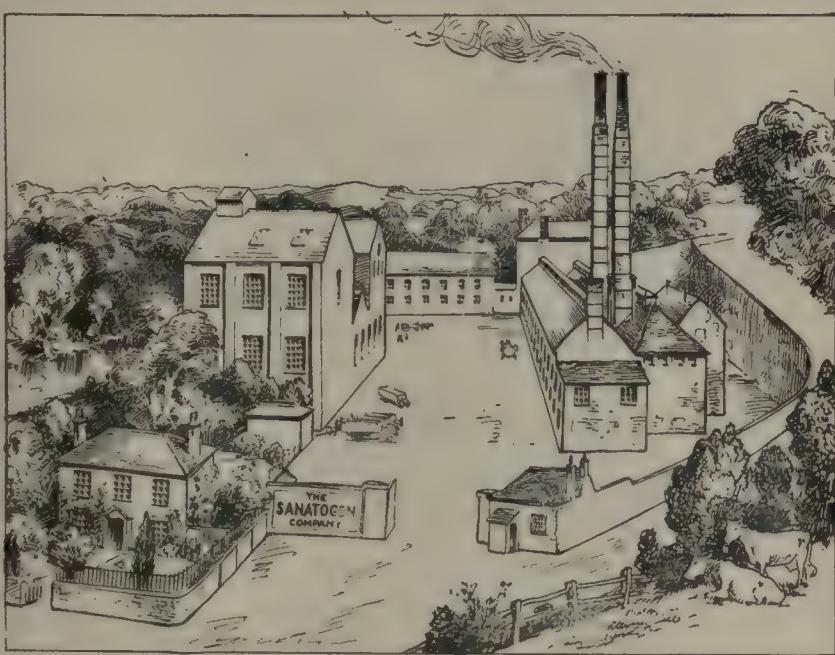
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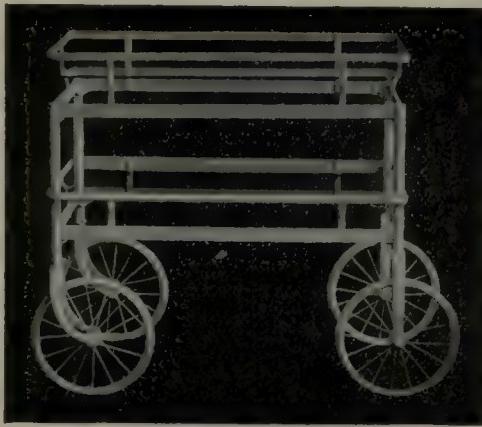
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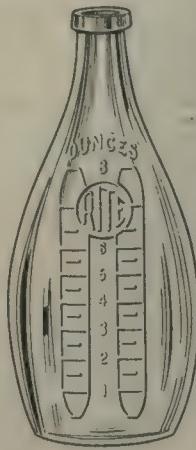
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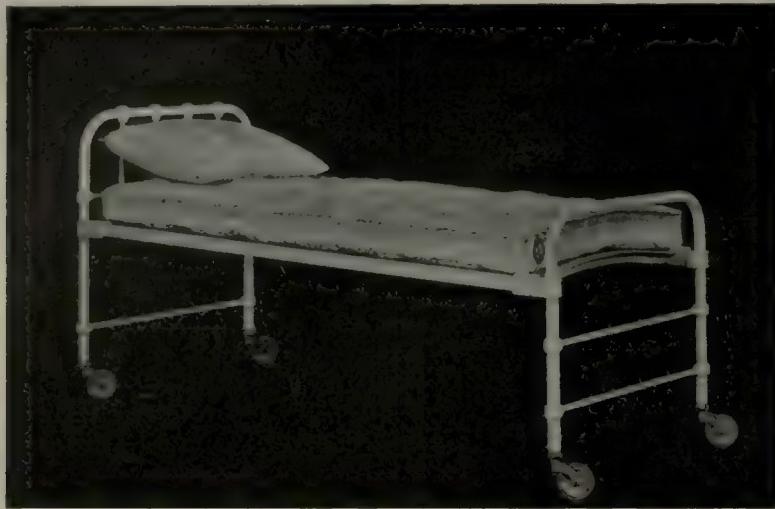
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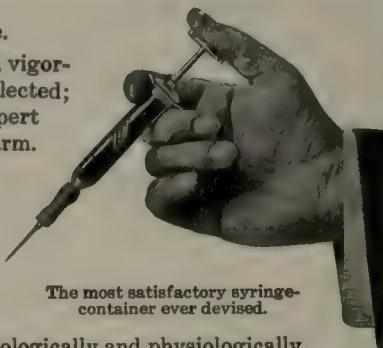
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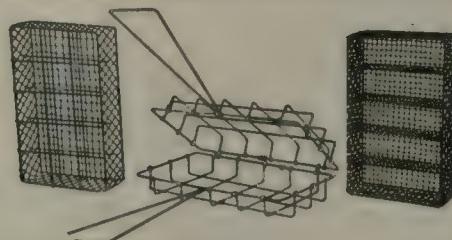
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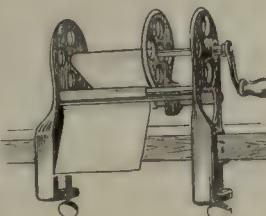
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The Hospital World

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Editorials

SYSTEM IN SUPPLIES

WHEN the newly constructed hospital is completed, and before the furnishings and supplies come in, it is most essential that definite and permanent places

be provided for the many thousands of articles included in the term "equipment."

The storerooms should be carefully and fully provided with shelves, drawers, boxes, bins, etc., in accessible and suitable places. The storekeeper must be able to locate the particular article or supply required the moment it is requisitioned, and this can only be accomplished by advanced planning of detail storage equipment, together with the exercise of care and accuracy in the receiving and distribution departments.

To facilitate this an index book, or suitable card indexes should be provided for listing all supplies. In some hospitals a card attached to each supply receptacle indicates not only what is placed therein, but the maximum capacity, the minimum permitted, the amount in at the moment, and any other detail convenient to know about the particular supply of drug, food, linen, etc.

Losses and breakages should be regularly reported, and the inventories changed accordingly. The steward, the druggist, and the matron are, perhaps, the three officers upon whom rests chiefly responsibility for system in these matters.

A few of the more recently constructed hospitals have installed Schwartz sectional cases to enable them to keep track of the drugs, and they are finding this method give satisfactory results.

"THE PATIENT IS RIGHT"

IN John Wanamaker's store in Philadelphia, one sees conspicuously placed throughout the place the sign "The Customer is Right." Mr. Statler, whose up-to-date hotels are so heavily patronized in Buffalo, Cleveland, and Detroit, has followed the same idea; and has placed here and there throughout the lobbies and corridors, for his employees' constant inspection, the sign, "The Guest is Right." And it appears to us that the superintendents of most of our public hospitals might well follow the leads of Messrs. Wanamaker and Statler, by having this sign in many places throughout their precincts—"The Patient is Right."

THE FRONT DOOR AND TELEPHONE

MISS AIKENS, in her widely-read book, "The Hospital Housekeeper," calls attention to the importance of having the proper person at the entrance door of hospitals to meet the general public. Here is where the first impression of a hospital is gained, and it should be favorable. The man in charge of this department should be one of gentlemanly deportment and possess a pleasing personality. He ought to be courteous and civil, always in possession of his temper, and should know as much of what is going on in the hospital as possible. The door boy in any first-

class club keeps track of all the incomers and outgoers, even though their number runs into the hundreds. So the porter or doorkeeper of a hospital should keep track of all who pass within and without the hospital portals. If the institution is of medium size he will be of great help to the management if he possesses himself daily of some knowledge of the condition of the patients, as well as a record of their names and the wards they occupy.

There should always be someone at the front door, not only to receive and direct visitors, but to be on hand whenever patients are admitted—that is, if patients are admitted by that route, which is usual in the smaller hospitals. It is very disconcerting to visitors, and particularly to patients, to enter a hospital unsaluted, and to be obliged to wait around several minutes before anyone “shows up” to receive them.

As Dr. W. J. Wilson says, this is one of the little points about a hospital which is a big point.

Original Contributions

HOW WE CAN BEST CONTROL THE SPREAD OF COMMUNICABLE DISEASES

BY M. B. WHYTE, B.A., M.B., ISOLATION HOSPITAL, TORONTO.

THE paper which I propose to read is in no way complete. The ever present obstacle to the elimination of communicable disease is the "carrier" and the "unrecognized case." We know that there are carriers of diphtheria and typhoid fever. We are not sure that there are carriers of scarlet fever and measles, though there are many instances of unrecognized scarlet fever spreading infection just as a carrier would spread it. A mild unrecognized case of scarlet fever might be termed a carrier by some. There are probably no measles "carriers," as the infection is so short lived that if the case shows no symptoms nor signs of measles there is probably no infectiousness. Fortunately these diseases are not communicable during the period of incubation, but infectivity begins with the beginning of symptoms, that is, with the beginning of the period of invasion, and it is this period of infectivity, which elapses before the diagnosis is made, which is chiefly responsible for our difficulties in lessening the spread of disease.

The success of any attempt to control the spread of disease begins primarily with the parents of children affected. It depends upon whether a mother is careful of her child's welfare, or whether she is careless. Even a perfectly organized department of health is helpless if a community, through ignorance or through intent, allow their children to lie ill without medical aid, and choose to rely upon home remedies. An Isolation Hospital controlled by the Department of Health was devised not only for the care of the sick, but also in the hope that by removing the infecting case from the home those left behind would be protected. But of what use is it, comparatively speaking, to remove a case from a home after it has remained

there for three or four days ill with diphtheria or scarlet fever unrecognized as such? In a great many cases the damage is done long before the case is removed. A certain amount of onus of responsibility rests upon the physicians in failure at times to make a prompt diagnosis of the case. Of course there are cases in which this may, at the moment, be impossible, but if suspicious cases could be as readily isolated for observation in the home as is possible in a modernly constructed and staffed isolation hospital, I believe that communicable disease could be greatly curtailed. But obviously this is impossible. Public health nurses present know, only too well, how difficult it is to carry out isolation precautions in the great majority of homes which they visit. We have ignorance, poverty and crowded quarters to deal with. Amongst the class more fortunate financially we still have to deal with a certain amount of ignorance which it will take time to meet by education of the general public, including the medical profession, in regard to the means by which disease is spread. I venture that if a vote were taken in Toronto, 999 out of every 1,000 would declare that communicable disease is transmissible through the atmosphere. If this is the case, how can we explain the fact that during the past five years over 500 medical students have taken clinics in the Isolation Hospital without contracting either diphtheria, scarlet fever or measles? Hundreds of parents have been allowed to see their relatives who may have been in a serious condition without a single instance of the spread of the disease. If infection is aerial in transmission, can you imagine a better spot to prove it than an acute diphtheria ward, where one can even smell the odor of decomposing diphtheritic membrane on the breath of the patients? The persons who have been exposed to this apparent danger do not bear a charmed life. There is no secret process by which they can be protected, and, if infection were air-borne, what could protect them as they breathe in the so-called infected air? We have a scientific method of determining whether a person is susceptible or immune to diphtheria, known as the Shick Test. Fifty-one members of the Isolation Hospital staff submitted to this test, and thirty, including myself, were found to be susceptible to diph-

theria. If infection is here, there and everywhere throughout the hospital atmosphere, what is to prevent these thirty members of our staff from contracting diphtheria? They have not contracted diphtheria because the infection is not present in the air they breathe. They do contract these diseases occasionally, which is readily explained by carelessness on their part in handling a patient or some article a patient has recently touched, without immediately cleansing their hands with soap and water. Speaking to an audience engaged in public health work, I am almost ashamed to find myself taking up your time proving the fallacy of air-borne infection and the actuality of contact infection. It is a point which has now progressed beyond the stage of argument, and yet the great mass of the people do not know about it.

I have gone into house after house where there is an infectious case and found the time-honored carbolised sheet hung over the bed-room door, but the mother going in and out at will without protecting her clothing with a gown or washing her hands. I understand the sheet is believed to prevent the escape of the germs, as though they drifted up to the door, received a sniff of carbolic and then fled. I am ready to ridicule this method because it is a waste of time and effort and gives a false sense of security. When the general public realize that the carbolised sheet is absolutely useless, they will cast about for something that is of use, and when they reach this mental state of helplessness, they will be willing to follow your instructions in the way of separate dishes, separate toilet articles, and the careful protection of the clothing of the attendant with a clean gown and the washing of the attendant's hands thoroughly after handling the patient or anything that the patient has touched.

If the carbolised sheet be explained as a danger signal to other members of the family, it may perform a useful service, but if reliance is placed in its antiseptic powers in preventing the spread of infection, it is of little value, in fact in occupying the attention which it does not deserve, other and more important channels of infection are in danger of being neglected.

I have discussed the value of a knowledge of contact infection because to control the spread of disease every household

must understand it, and it is the duty of the Department of Public Health to educate the public along these lines. A Department of Health which encourages the very early reporting of disease, and then quarantines the patient and probably one attendant, leaving the bread-winner to remain at work, in this way not overly interfering with the liberty of the people, should accomplish most. The tendency at the present time is toward rational action in the place of arbitrary control, and this has been made possible by our recent knowledge of infection by contact.

In the discovery of the mode of infection by contact all honor must go to Louis Pasteur. Pasteur demonstrated in the Pasteur Institute in Paris that various diseases could be cared for in the same wards, provided the nursing technique were perfect in ruling out the possibility of contact infection.

Now it might be worth while to consider the more common diseases as to our ability to prevent their spread. I think we should gain a lesson from the remarkable control over smallpox which it is possible for a Department of Health to have in its power to enforce universal vaccination. Vaccination has done wonders for the public and how little the public appreciate it. Vaccination has made the soil (in this case the human body) unfit for the development of the smallpox organism. The result has been a lessening in virulence so that the almost fatal confluent and fatal hemorrhagic smallpox are things of the past. This has been done by making the public *immune* to smallpox by vaccination.

Now those exposed to diphtheria might also be immunized with antitoxin, the immunizing effect lasting about two weeks. As opposed to this plan, Dr. Chapin, of Providence, claims that symptoms would be masked or lacking if the immunized patients were to harbor diphtheria germs in their throats, and "carriers" instead of "clinical cases" would develop, taking it for granted of course that unrecognized carriers are more dangerous than recognized clinical cases. It is difficult to argue against this reasoning, but personally I would prefer for the individual's sake that a man be a "carrier" rather than a "clinical case," and I believe that the poor who are loath to

call a doctor until it may be too late, should have the benefit of an immunizing dose of antitoxin as soon as the first case is recognized in the household. Immunization is carried out in this way in the treatment of scarlet fever at the Isolation Hospital. Ordinarily post scarlatinal diphtheria is a very common complication or sequel of scarlet fever, and this troublesome condition in hospitals for communicable diseases has been practically eliminated by the use of antitoxin as an immuniser. Carriers are occasionally discovered, but clinical cases are exceedingly rare and give us no concern whatever. As, therefore, antitoxin is of value in preventing the spread of diphtheria amongst scarlet fever patients in a hospital, it might prove equally beneficial in the homes of the poor who do not receive constant or immediate medical attendance, and if "carriers" should develop rather than "clinical cases," it is a simple matter to swab the household and quarantine the carriers if desired. This method of at least controlling clinical cases of diphtheria is often employed by the family physician, but I do not believe it has been attempted in a systematic way by the Department of Health in Toronto.

Scarlet fever presents an insurmountable difficulty from our lack of knowledge of the infecting organism. Whether or not a convalescent scarlet fever patient is free of infection we can only hazard a guess. We know that the farther you get from the acute eruptive stage, the less the danger of infection, consequently to shorten the period of quarantine can hardly be expected to more efficiently control the spread of scarlet fever, though it may be possible that we are a little over-cautious in quarantining for six weeks. There are many instances in which this seems to be the case, and yet I have seen much evidence of the reverse. Late desquamation does not spread the disease, while moist discharges from the nose and ear are likely to. How long these discharges really remain infectious I do not know, but cases of this nature are quarantined in the Isolation Hospital for ten or twelve weeks, while cases are not kept longer than six weeks because of desquamation.

All that we can do at present is to depend upon an early diagnosis, removal of the infecting case, and exercise great

care in releasing cases from quarantine. The latter procedure is a difficult matter, for there are convalescing cases in which it is impossible to say absolutely whether or not the patient is still infectious. Many cases, having fulfilled the required period of quarantine and clean in every respect, healthy looking throat, no discharge from ears or nose, and even free of desquamation, have been known to be a source of scarlet fever to others.

Measles has made itself felt unmistakably in Toronto during the past few months, and yet Press and Public alike continue to make light of the disease, and many attempts at humorous articles and sorties are made in ridicule of the serious attitude of the Department of Public Health toward this disease. Typhoid, a disease common in early adult life, is greatly respected and avoided. Measles, the children's disease, is scoffed at as being of no consequence. Mothers deliberately expose their children to the disease with all its dangers. I know of one instance at least in Toronto of a mother placing one healthy child in bed with another with measles, in order that she would contract the disease and have it over with. In this instance the child so exposed with intent, contracted measles and died.

During the past year there were nine deaths due to typhoid fever, sixty-six from diphtheria, fourteen from scarlet fever, and eighty-two from measles; in other words, nine times as many deaths from measles as from typhoid fever, and the number of deaths from measles exceeded by two the number of deaths from diphtheria and scarlet fever combined.

What can we do to control the spread of measles? Here again we have to resort to early diagnosis and prompt and effective isolation of the case. There is a point in the diagnosis of measles which does not receive the attention that it deserves from the medical profession, and that is, the recognition of so-called Koplik spots in the mouths of cases of measles. They are tiny white glistening bodies about a pin point in size surrounded by a red areola about the size of the head of a pin. They are found in eighty per cent. of cases of measles and appear early in the catarrhal stage before the rash makes its

appearance on the skin. With fever, a cough or sneeze, and the presence of Koplik's spots, the diagnosis can frequently be made a day or two before the appearance of the rash. This point might be taken advantage of in the routine examination of those exposed between say the tenth and fifteenth day after the removal of the infecting case. This would to some extent shorten the duration of exposure to the most infectious period of measles, the period of invasion.

In conclusion it may be fairly said that our success in controlling the spread of communicable disease depends upon early diagnosis and reporting of cases, education of the public as to the all-important transmission of disease by contact, and a well organized, ever vigilant Department of Health to lead the way in putting these principles into practice in the most effective way.

THE PRACTICAL NURSE QUESTION

A Two Years' Study in Detroit

MISS C. A. AIKENS, DETROIT.

SINCE the beginning of 1914 the Detroit Home Nursing Association has been making a study of the best means of managing the practical nurse question in Detroit. The record of service in more than 1,000 homes is on file, and a large amount of information relative to the general situation has been secured. Backed by a group of representative medical men of the city, by superintendents of some of the larger hospitals, and by leading citizens, the effort has been made to build up for service in homes of families of moderate means, a corps of reliable workers who would work under the direction of graduate nurse supervisors, to whom they might appeal in any time of doubt or emergency. The aim has been to send to each home calling for assistance the kind of nurse best fitted to the needs of that home, to safeguard the interests of the

home and of the worker—in short, to give an all-round practical form of nursing service for such homes at the lowest expense possible with justice to the worker.

Of the value of the household or practical nurse in certain classes of cases and homes there is little dispute. In the cases in which the patient can be considered separate from her home and family, a graduate nurse should be called. But in a large majority of cases not the patient alone but the home needs to be cared for, and the woman who, besides caring for the sick, is willing to get meals, keep the home in order, see that the man's dinner pail is gotten ready and the children washed, dressed and off to school, is in demand and will continue to be in demand. How to increase her efficiency and minimize the difficulties under which she labors has been made a subject of special study in Detroit during the years 1914 and 1915.

Two important difficulties exist in regard to this class of workers from the standpoint of the public. First, the practical nurse is (often through no fault of her own) pressed into service on critical cases where a high degree of nursing skill is needed. Second, the tendency with many practical nurses is to unduly increase their prices for their service. From the standpoint of the practical nurse herself, the difficulty exists in many homes that the family resolve to get all the work possible out of her. They plan for unusual and unnecessary labor to be done during sickness, make no provision for needed sleep, and often ask her to wait months for her money. It is often found that the household nurse who is caring for a sick mother, and perhaps a child besides, will be expected by some relative to do the house-cleaning in addition, to do large washings, to scrub carpets, and do various other kinds of work which should never be expected of her. No woman can do such work in a home without neglecting the patient, who should be the first consideration, but often is not. Many complaints about practical nurses in regard to neglect of the patient arise from this cause. Thus it is that the superintendent of the association providing such service becomes in many cases an adjuster of domestic conditions—always insisting on the patient's interests being placed first and the housework being

limited to necessary duties—duties which are essential to be done for the comfort of the household.

During the two years' study of this situation 403 women have applied to the Detroit Home Nursing Association asking to be placed on their list of workers. Out of this number, the superintendent accepted 107. Of these twenty-seven were rejected after a trial, leaving a staff of eighty household nurses at the beginning of 1916. Since that date several more workers have been added to the accepted list.

The reasons for the rejection of the twenty-seven, who seemed to have in them possibilities of becoming fairly good workers, and who brought with them excellent recommendations, are in general as follows: Some were untruthful—this fault was frequently discovered in those whose recommendations were of the best. They were "gossipy"—could not control their tongues, discussed physicians and the association promiscuously, and had no idea of loyalty to anybody. The little unruly member is difficult to deal with in pupil nurses and in graduates who have had a three year training—everyone familiar with the situation knows this. It is still more of a problem with the untrained woman, in spite of all the instruction and warning that the superintendent can give. Others had "men followers"—too many of them, who were taking them from their work for long telephone conversations to the neglect of the patient, or who called for them in the evenings and brought them back after midnight—unfit to give efficient service to the patient and family next day. They were in the main women who were capable of giving fairly good service but for these personal failings.

The 296 who were rejected without trial were rejected by the superintendent for the following reasons:—

1. A large proportion of them were found on careful questioning to have no serious intention of staying in this line of work for any length of time. They were simply taking it up as a temporary "tideover" till they found some job better suited to them. Many of them were "canvassers," who did not like to be out canvassing in cold weather, and who did not wish to be in the sick room in warm weather.

2. A considerable number objected to the superintendent insisting that they must not wear white dresses while on duty, and must have a supply of colored working aprons. They wished to copy the graduate nurse as far as possible, in their dress and in the restriction of their work in the home. They refused to do housework.

3. A large number objected to the association fixing the rates for service. They spurned the idea of working for \$2 to \$2.25 a day, and demanded \$25 a week in some cases.

4. Others were too profuse in their own praise. They had had perhaps two or three cases and felt they were equal to the most difficult situations. Their self-confidence condemned them as unteachable and dangerous—the type who would not hesitate to prescribe for a patient without bothering a doctor to attend to that part of the work.

5. A number of these applicants presented themselves dressed to resemble a Paris doll—face painted and powdered, tawdry finery, sham jewellery in the shape of bracelets, earrings, lavallieres, hair ornaments, etc. This type may, occasionally, with instruction, develop into efficient workers, if given a trial, but ten chances to one they will not.

6. A considerable number of women—especially those who had had some experience in the care of the sick, objected to being supervised by a graduate. The term "supervised" was seldom used in dealing with them—the terms "assist" and "teach" are generally used by the superintendent in her conversations with them—but a lot of practical nurses know too much to be taught. The association, like the hospital workers, has learned to prefer the nurse who knows nothing about the work, but who is willing to be taught and eager to become more efficient.

7. Many who applied were not neat or clean in their habits or dress. A careful scrutiny showed lack of cleanliness about clothing, neck, ears, hands, etc. Judging from the odor of perspiration which they exuded, they were badly in need of a bath and a clean set of underclothes. Such women are undesirable in the sickroom, however willing they may be to serve. Some cases of this kind, who otherwise seemed promising,

ing, were given a trial in the hope that if they were given a chance for regular baths, etc., their habits would improve in this respect.

8. Several presented themselves as applicants with the odor of intoxicating liquor on their breath.

9. Several had disagreeable physical defects—nasal catarrh, "running ears," etc., and a few applied whose appearance suggested the presence of a serious specific disease.

10. The others, who might be grouped in the class of "doubtful characters," were most insistent in their stipulation that they have their "off duty" hours at night, yet would give no reason for this stipulation. A little probing showed that they were fond of frequenting public dance halls and such places at night, and that the time they arrived at the home of their patient at night did not matter.

Of the 403 applicants, six had had a correspondence course in nursing, of some kind. Two of these were given a trial. Both were women of good character, who seemed to have possibilities of usefulness in some way in this field. One was a nicely refined old lady whom the superintendent thought might fit in in certain places where the work was not very difficult. She had paid one hundred dollars for the course she had taken from a correspondence school. She was too old to learn practical methods, and unable to apply such knowledge as she had acquired, so had to be dropped. The other, a young woman perhaps thirty years of age, and who seemed intelligent and promising, was "self-opinionated." She was sent to several cases, but did not seem ever to get along smoothly with the family, and resented the superintendent's suggestions as to how she might improve. She was also dropped as unsatisfactory.

About half of the 403 applicants had had some experience in hospitals. Most of these were probably rejected probationers. A considerable number had worked in a sanitarium of some sort. Some had been obliged to interrupt their training course in hospital, and family reasons made it necessary for them to earn money at once. Inquiry at the hospitals from which this class of workers had been showed that their record

had been fairly good, and in some cases the hospitals would have been glad to have had them return to complete their training.

The rejected probationer is by all odds the most difficult type to deal with. She is the one who wants to wear white dresses on duty, who wishes to be known as a "trained nurse," who objects to housework, who is most insistent that her hours off be at night, who resents instruction, and who wants to charge \$25 a week for her services.

In the list of those accepted as workers are many splendid women—many of them widows who have learned much in the school of life which the young graduate has yet to learn. They are careful to obey orders, eager to increase their efficiency, economical in the management of the household affairs, and give a large measure of willing service. Many of them are refined and intelligent, whose character is above reproach. Such women appreciate the standards of service which the association endeavors to maintain and the assistance which such an organization affords. Experience has proven that the graduate nurse and the practical nurse can work together harmoniously, each doing that which she is best fitted to do, and both striving to render to the sick in homes of moderate means, prompt and efficient service.

Selected Articles

NEED OF A SCIENTIFIC RESEARCH HOSPITAL

IT IS absolutely certain that alcohol and its relation to the individual and community will become one of the most intensely personal topics in the near future. One reason is, that above all questions, this is the most intimately associated with the home life and social interests of every community.

Already it has come into politics; it is becoming an absorbing theme in all religious and sociological circles; it is a serious question in commercial and economic centres, and discussions concerning its influence are increasing in prominence every day.

It is asserted from a study of vital statistics that alcohol is either directly or indirectly responsible as an active cause of the deaths of over 100,000 persons yearly in this country. Authorities who are competent to judge, assert that these statements are by no means extravagant.

Observations show that the victims of alcohol include the most active, capable, efficient men and women in the country; also that culture, training, wealth and position are no exemptions to the influence of this terrible evil. The fascination for alcohol enslaves the millionaire as well as the pauper, the learned and the unlearned, and extends to persons in every possible condition and walk of life.

Scientifically we know from laboratory studies, the general effects of alcohol on cell and tissue. From vital statistics we know its influence on the health and longevity of the race, but beyond these two facts there is a vast unknown region that is described and explained by theories, personal opinions and traditions that have come down from the past, which are contested, disputed and largely unverifiable.

In this region, the unknown facts are, What are the causes that impel men to use alcohol to their own destruction? What conditions of heredity, nutrition, environment, infancy, growth, development and training; what diseases, injuries, both mental

and physical, and what occupations have prepared the soil, planted the seed and actually cultivated and developed the craze for alcohol?

We all realize that there are no chance or accidental occurrences in this world. The same reign of law, concerning causes and effects, exist here as elsewhere. When the causes and conditions of disease, fevers and other great scourges of the race have been ascertained, effectual means and measures have been applied, which have literally stamped them out.

Here, an exact knowledge of the causes was necessary before successful preventive and curative measures could be determined. Up to this time all remedial and preventive means and measures for relief from the alcoholic evils have been based on the assumption of certain distinct causes, about which we have no data or positive facts.

The time has come for a scientific research hospital, where the conditions which cause the drink evil can be studied, tabulated and examined, and the laws which govern and control them can be determined.

Such a hospital would be practically a clearing house for the continuous examination and study of alcohol addicts, and all the influences, physical and mental, which control them. Here can be found the physiological, psychological and pathological laws which shape the growth and destiny of the victims.

A research hospital will appeal to physicians, health boards, life insurance companies, to state institutions and laymen, as a centre for exact study, counsel and advice on all matters pertaining to this subject. It would furnish statistics and data with suggestions of the value of practical measures for relief and prevention.

In this way it would be of inestimable value in every effort made along humanitarian lines. This must be done by an independent central authority, above all theories, personal opinions or traditions of the past. This work is imperatively called for by the spirit of the age, which demands exact knowledge of the causes of any evil, before rational means and measures for relief can be applied.

This is an evolutionary movement that will be welcomed, and it is from such a hospital that we shall know how the bur-

dens of disease can be lifted, how the sufferings of humanity can be diminished, and in this way the great alcoholic evil can be known, controlled and prevented, the same as other diseases. Scientific investigators are searching to-day for the causes of cancer, and trying to find the germs of pellagra, as well as the sources of many other diseases, with exact scientific scrutiny, and with a certain promise that they will be discovered and driven out. Why should not the alcoholic problem be studied in the same scientific way and in the same spirit with enthusiasm and determination to discover the facts and utilize them?—*Exchange.*

REPORT ON NEW YORK CIVIC HOSPITALS

THERE has recently been issued one of a series of reports by a committee of inquiry into the management of Bellevue and allied hospitals, New York City. The *HOSPITAL WORLD* is in receipt of section IX, issued dated 1913, on food, buildings, and control forms. The investigation and report were made under the direction of Mr. Henry C. Wright.

Herewith follows:—

SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

WITH REGARD TO

HANDLING OF FOOD AND FOOD WASTE.

A. *Summary of Findings:*

BELLEVUE AND ALLIED HOSPITALS.

1. The amounts of the various kinds of food used in Bellevue and its allied hospitals were determined for the year 1912. Considerable variation was found in the amounts of like kinds of food used in the different hospitals. Of meat, Bellevue

Hospital used 344.82 pounds; Harlem Hospital, 372.5 pounds; Gouverneur Hospital, 319.6 pounds; and Fordham Hospital, 393.6 pounds per capita in the year. Fordham Hospital used 84.2 pounds of mutton per capita in the year, as compared with 44.1 pounds used by Gouverneur Hospital. Of poultry, Bellevue Hospital used 42 pounds per capita during the year, as compared with 79.5 pounds used by Harlem Hospital, and 83.4 pounds used by Fordham Hospital. The consumption of milk by Harlem Hospital was 733 pounds, whereas Fordham Hospital used but 547 pounds per capita during the year. (Page 19.)

2. The requisitions from the allied hospitals are passed upon by the dietitian at Bellevue Hospital without a knowledge of the number for whom such food is required in these hospitals. (Page 20.)

3. The amount of food estimated for in the budget of Bellevue Hospital is determined in the accounting department, without consultation with the Dietitian. (Page 20.)

4. The requisitions for food made out by the Dietitian in Bellevue Hospital apparently are not based upon the fluctuating census of the hospitals. During the first six months of 1912 the average daily census of patients was 1,324, and the weekly issue of meat* was 4,671 pounds. During the second six months of the year the average daily census was 1,171, while the weekly average issue of meat was 4,733 pounds. Thus, it will be seen that more meat was used in the gross during the second half of the year, although the average census was 153 less, than during the first half of the year.

The average daily issue of meat per patient during the week ended April 28, 1912, was .48 pound, and approximately this same ratio was maintained in the months of March, April and May. Had this ratio been maintained throughout the year Bellevue Hospital would have used 217,774 pounds of meat

* The term "meat," as used in this Report, includes poultry and fish.

for the patients, instead of the 244,289 pounds which were actually issued.

During the months of March, April and May, 1912, the average census of patients in Bellevue Hospital was 1,337. During these months the average monthly issue of eggs was 9,708 dozen. During August, September and October, when the average daily census of patients was 1,159, the average monthly issue of eggs was 9,740 dozen.

During 1912 Bellevue Hospital used 94,926 pounds of fowl. Of this, the patients used approximately 37,540 pounds. The remainder, 57,386 pounds, was used by officers and employees. The average number of employees was 1,013, and of patients, 1,243. (Pages 20 and 21.)

5. The patients in Bellevue Hospital received, on an average, about one-half pound of meat per capita per day. Had the officers and employees consumed a pound of meat per capita per day the total consumption of Bellevue Hospital for the year 1912 would have been 596,682 pounds. The actual issue was about 771,075 pounds. The meat used for officers and employees in excess of the ratio of one pound per capita per day cost approximately \$20,900. (Page 21.)

6. At the request of your Committee, the amount of waste food returned from the plates in four dining-rooms at Bellevue Hospital was weighed by the employees in the dining-rooms during a week in the fore part of June, 1913. The waste in the staff dining-room averaged 1.4 pounds per capita per day, and in the Nurses' Residence 1 pound per capita per day. The highest average per capita waste in any of the dining-rooms at Kings Park State Hospital, where waste is carefully guarded, was .33 pound per day. The lowest per capita waste noted in Bellevue Hospital was .42 pound per day, whereas the average per capita waste in Kings Park State Hospital was .23 pound per day. (Page 23.)

7. An employee of your Committee, during the latter part of July and the fore part of August, 1913, separated the waste

returned from the plates after each meal in the staff dining-room and in the dining-room of the Nurses' Residence during a period of six days. As a result of this careful analysis of the waste it was found that in the staff dining-room, which fed on an average about 200 daily, the total waste of meat alone was about 230 pounds. On one day 25 pounds of porterhouse steak were returned with the plates, and, at the same time, 38 pounds remained in the pantry, cooked but not served. The average daily waste of food returned from the plates in this dining-room was 215 pounds.

The dining-room in the Nurses' Residence serves approximately 350 persons per meal. During the six days in which the waste was segregated by an employee of your Committee the total waste of meat returned from the plates was 285 pounds. On one day 89 pounds of steak and chicken were returned, and on another day 55 pounds of Irish stew and veal were returned. The average daily waste of all foods returned from the plates was 281 pounds. (Pages 21 to 28.)

Department of Public Charities.

1. According to the Storehouse records Metropolitan Hospital received 431,000 pounds of beef during the year 1911. According to the distribution records of the Dietitian, the butcher delivered to the kitchen 311,000 pounds, which indicates an unaccounted for difference of 27 per cent. (Page 29.)

2. The delivery records in King's County Hospital were checked for the first week in January, 1912. According to the Dietitian's records the kitchen received 3,422 pounds of beef, bone, and stock. According to the delivery records of the butcher he sent to the kitchen during this same period 4,051 pounds. There seemed to have been no knowledge of the discrepancy between those two sets of records, and no attempt to reconcile them. (Page 29.)

3. In the State Hospitals for the insane there is not more than 2 per cent. variation between the records of the amount

received by the butcher and the amount delivered to and received for by the kitchens. (Page 30.)

4. The gross amount of all kinds of food used by the different hospitals in the Department of Public Charities varies markedly. Kings County Hospital used 1,376 pounds of food per capita per year, as compared with 1,649 in City Hospital, and 1,722 in Metropolitan Hospital. (Page 31.)

5. The difference in the gross amounts of food used in the different hospitals also represented a difference in the amount of food elements; viz., protein and calories. Kings County Hospital used food containing on an average 108 grams of protein per capita per day, as compared with 138 in City Hospital and 143 in Metropolitan Hospital, while Bradford Street Hospital used 162. The calories contained in the food used in Kings County Hospital amounted to 3,021; in City Hospital, 3,820; in Metropolitan Hospital, 3,795. (Page 31.)

6. Metropolitan and City Hospitals used more beef during the summer months, when fresh vegetables were abundant, than during the winter months, when vegetables are obtainable only in dried or canned forms. The average daily per capita consumption of beef in City Hospital in the six months ended March, 1911, was .48 pound, and in the following six months .485 pound. In Metropolitan Hospital it was .515 pound in the winter months and .55 pound in the summer months. (Page 32.)

7. The patients in the hospitals of the Department of Public Charities received more food per capita per year than the inmates of the State insane asylums. The average consumption in five of the large State hospitals for the insane during the year 1910 was 1,236 pounds. The average issue in the hospitals of the Department of Public Charities for the year 1911 was 1,605 pounds. (Page 32.)

Department of Health.

1. A marked variation was noted in the per capita amount of food used in the different hospitals of the Department of Health. Willard Parker Hospital and Kingston Avenue Hospital largely care for the same class of patients. Willard Parker Hospital used, during the year 1912, 1,655 pounds of food per capita, while Kingston Avenue Hospital used but 1,371 pounds per capita. In the amount of food supplied at Willard Parker hospital there were 116 grams of protein per capita per day and 3,205 calories. In the food supplied at Kingston Avenue Hospital there were 87 grams of protein per capita and 2,578 calories.

The Sanatorium at Otisville, which cares exclusively for tuberculous patients, used 1,772 pounds of food per capita, whereas Riverside Hospital, which cares for both tuberculous patients and some patients of mixed contagions, used 2,207 pounds per capita. Tuberculous patients are supposed to be fed on a heavy meat diet. These patients at Otisville received 415 pounds of meat per capita during the year. The tuberculous patients at Riverside Hospital, including some cases of mixed contagion, received 464 pounds of meat per capita. (Page 34.)

(To be continued.)

Hospital Notes

CANADIAN NURSES' HOSPITAL

THE Canadian Red Cross have just completed arrangements acquiring Kingscliffe Hostel, Cliftonville, Margate, as a Convalescent Hospital for Canadian nurses. When fully equipped it will accommodate 75 patients. It was opened April 1st.

WESTERN UNIVERSITY OFFERS A COMPLETE HOSPITAL UNIT

IT IS understood that President Braithwaite, of the Western University, London, Ont., recently offered to the Government, on behalf of the Institution named, a complete Field Hospital Staff for Overseas Service.

WOMEN'S COLLEGE HOSPITAL, TORONTO

THE monthly Board Meeting of the Women's College Hospital, 125 Rusholme Road, Toronto, was held on Wednesday afternoon.

Gratifying reports of the work were presented. During January all the twenty-two beds in the hospital were occupied, and patients had to be refused. During February there were fourteen public ward patients, two of whom were from the Township of York.

The income for the last two months (including the Government grant not yet received) was slightly in excess of the running expenses.

A movement is on foot to clear off all the indebtedness on the property and make needed enlargements.

Mr. G. A. Warburton addressed the Board upon the best method of inaugurating a campaign for this purpose.

Obituary

R. W. BRUCE SMITH

FOR a year past intimate friends of Dr. Bruce Smith have been apprehensive that the illness from which he was suffering would not respond to the treatment given; and as the stormy month of March drew to a close, Dr. Smith's life ebbed away.

Deceased was one of the best known men in the medical profession, and also one of the best liked. Following a goodly period of strenuous town and country practice, Doctor Smith entered the asylum service and rapidly became eminent as an expert alienist, being frequently called by the Crown on important cases of a medico-legal character in which the question of insanity was to be considered. Our confrere also became well posted in criminology and took the liveliest interest in Prison Reform. In him, Mr. Hanna, the progressive Provincial Secretary of Ontario, found his right hand man. To Doctor Smith was assigned much of the detail connected with the establishment of prison farms and other places of detention in conformity with the newer views respecting the management of prisoners. The province has also to thank him for his work in connection with the securing the new site, near Whitby, of the new Hospital for Insane located there, and for much of the planning of the excellent buildings. Many hospitals and sanitariums, too, owe much of their excellence to Dr. Smith's advice.

One has only to read his annual reports on Hospitals and Charities to form some conception of the fine work the late inspector did for the Province. His reports are models, not only on account of their contents, but because of their fine literary presentation.

Doctor Smith was always on the alert to secure the latest and best ideas in respect to the building, management and equipment of hospitals and prisons. He made several visits to Europe, absorbing what was best there for use here. He was

also a constant visitor of medical and hospital associations, having been President of the Ontario Medical Association, and an honorary member of the American Hospital Association and of the British Hospitals' Association. At these meetings the kindest face and the friendliest hand and the most cordial greeting to his fellow workers were those of Dr. Bruce Smith. Many a weary, overwrought hospital superintendent has been cheered and has taken a new grip of things after one of his genial visits and kindly words of counsel.

Dr. Bruce Smith will long be missed by his hosts of friends throughout Canada. We trust the good things he has initiated will be carried on by able hands.

To his brave and always helpful companion, Mrs. Smith, and to his sister and daughters the HOSPITAL WORLD extends deepest sympathy in their irreparable loss.

J. N. E. B.

Book Reviews

Essentials of Medical Electricity for Medical Students and Nurses. By GEORGE K. ABBOTT, M.D., Professor of Clinical Medicine, College of Medical Evangelists, Loma Linda, Cal. 12mo of 132 pages with 87 illustrations. Cloth, \$1.25. W. B. Saunders Company, Philadelphia, London. Sole Canadian Agent, The J. F. Hartz Co., Ltd., Toronto.

Implying a knowledge of elementary physics, this manual provides a comprehensive text-book on the main fundamental principles of electro-therapeutics, written in simplified terms to make it suitable as a book of first instruction. The author is a teacher who appreciates the value of a careful explanation of the principles underlying electro-therapy and develops his text in an interesting and practical manner, using many illustrations and diagrams (87) and has appended to the early chapters a series of "Questions for Review," making the book a very practical one, especially as a laboratory text-book.

The contents embrace Galvanic Electricity, the Cells and the Battery, Electrolysis and Cataphoresis, Electrotonus, Faradic Electricity, Sinusoidal Electricity, Technic and Prescriptions, Electrodiagnosis, Static Electricity, and High-frequency currents. There is an ample index to the 126 pages. C.J.C.

Hospitals and The Law. By EDWIN VALENTINE MITCHELL, LL.B., of the Faculty of the College of Law, University of South Dakota. New York: Rebman Company, 141, 143, 145 West 36th Street.

This little volume of 180 pages should be welcomed by hospital administrators, legal advisers, medical staff and trustees. A study of it will show how various pitfalls may be avoided. Mr. Mitchell presents a short analysis of the general propositions of law relating to health institutions generally. The

author aims to the subject readily comprehensible to all who are interested in the professional work of hospitals. Mr. Mitchell goes into the question of the foundation and organization of these philanthropic institutions; points out their sources of support; discusses their administration and regulation, rights and responsibilities; and devotes a chapter to the relation of officials and attendants to the patients. The bare mention of these topics shows that the writer of the book attacks the problems in a fundamental way. Many concrete examples in the form of abstracts of reports of trials will be read with particular interest.

Of added interest and very apropos now are the supplementary chapters on the military and naval hospitals. Six of the eight chapters of the provisions of the Geneva convention of 1906 are cited. A tabulation of cases quoted and a good index complete the volume.

A Text-book of Physics and Chemistry for Nurses. By A. R. BLISS, JR., M.D., and A. H. OLIVE A.M.; Phm.D., published by J. B. Lippincott Company, Philadelphia and London, \$1.50 net, 49 illustrations.

This will prove a valuable reference book for nurses' libraries, in schools where physics and chemistry are not taught directly, because the standards of admission to such include a preliminary training in these subjects. In such States as may be found whose standards are not so high, where, after the nurses enter, it is found that these subjects must constitute a part of the curriculum, this book will, no doubt, prove acceptable to the authorities, and compete most favorably with any others sent for their approval to be standardized for the whole state. There should be uniformity in text-books throughout any state. The text of this work naturally, like any on this subject, requires accompanying demonstration and experiment. The illustrations are good, and the language clear and simple. It is divided as follows. Part I. Elementary Physics; Part II. Inorganic Chemistry; Part III, Organic Chemistry; Part IV. Physiological Chemistry; Part V. Fermentation, Ferments,

Disinfectants, etc. In the appendix are found the weights and measures, the metric system, a useful glossary and a percentage solution table. The subject-matter in this work is modern, and omits nothing that will come within the nurses' hearing, and thus she can refer to this and get a clear concise idea of the nature of whatever new substance she hears mentioned.

The Social Emergency. Studies in Sex Hygiene and Morals.
Edited by WILLIAM TRUFANT FOSTER. Boston, New York,
Chicago: Houghton, Mifflin Company.

The author, who is President of Reed College, Oregon, holds that any plan for meeting the social emergency that would relax the control of moral and spiritual law over sex impulses is antagonistic, not only to physical health, but as well to the highest development of personality and to the progressive evolution of human society.

"The Social Emergency," Dr. Foster defines as the result of breaking away from the conspiracy of silence concerning matters of sex and reproduction. Most boys and girls have no opportunity to hear sex and marriage and motherhood discussed with reverence; having only heard them discussed with vulgarity.

William House, who contributes a chapter on the physiological aspects of the question, quotes Dr. Howell, of Johns Hopkins, who holds that so far as the individual is concerned his sexual functions may be unused or he may be completely unsexed without any injury to bodily health.

Dr. Andrew Smith, on the medical phases, calls attention to the alarming frequency of gonorrhea and syphilis and their frightful sequelæ. He holds that when boys are made clearly aware of the simple sex principles, they will not become victims of these diseases, nor addicted to sexual abuse, nor will they become seducers of girls.

Discussing the economic phases, Dr. A. C. Wood says that of the 65,000 women who are adrift in the United States, the majority are receiving less than the minimum cost of decent living, and hence are in "a perilously defenceless state."

Recreational, educational, moral and religious phases of the question are discussed by experts. Chapters are devoted to the presentation of the subject to boys and girls; and the various agencies, methods, materials and ideals are dwelt upon.

Fever Nursing. By GEO. P. PAUL, M.D., Formerly Assistant Visiting Physician and Adjunct Radiographer to the Samaritan Hospital, Troy, N.Y. Philadelphia and London: W. B. Saunders Company.

In this book Dr. Paul has given not only the care and treatment of fevers in general, telling us what to do and what not to do, but he has with a particularity described the nursing needs in the various infectious fevers. In the chapters on this subject he deals with the etiology, symptoms, diagnosis, prognosis and complications of the disease. As an early recognition of complications commonly devolves on the nurse he has discussed in detail what these are in typhoid, smallpox, scarlet fever, etc.

The matter of isolation, length of quarantine and effective methods of disinfection receive due attention.

The New Public Health. By HIBBERT WINSLOW HILL, M.B., M.D., D.P.H., Late Director, Division of Epidemiology, Minnesota State Board of Health; Director, Institute of Public Health; and Medical Health Officer, of London, Canada. New York: The Macmillan Company, 1916.

Dr. Hill's book pays due recognition to the work of Chapin in connection with the way the so-called contagious diseases are transmitted. He shows the futility of the older methods of prevention, which laid emphasis on clean back-yards, drainage, ventilation, water closets and the like. The new public health focuses on the discharges of the patient and their transmission by hands and utensils to the mouths of other people who thus become infected. How to check such transmission by segregation of the suffering victims, and by blocking the

routes are described by the author. The old technique was practically worthless, in so far as the prevention of contagion was concerned. By a strict observance of the new rules many of the contagions will ere long become *non est*.

Dr. Hill's book is written in a forceful, though unconventional manner; and lays the emphasis in regard to Public Health where it properly belongs.

For community defence there is need of the joint labors of the bacteriologist, the chemist, the public health engineer, the statistician and the epidemiologist.

Not only should a Health Department concern itself with the prevention and eradication of disease; but, Dr. Hill maintains, it should aim at the promotion of high health.

"HOSPITAL MANAGEMENT" is the name of a new hospital magazine, volume I, number 1, issued in February, having reached our desk. It is published by the Crain Publishing Co., Louisville, Ky. It contains a survey of contagious hospitals; has an article of the New York Hospital Laundry; contains a description of the Youngstown Sheet and Tube Company's Model Industrial Hospital; and describes the record system of Louisville City Hospital. It contains 33 pages, and has a fair number of advertisements. There is no announcement as to editorial staff, but we surmise the *dens ex machina* is the genial and poetical administrator of a new southern hospital. We wish our young contemporary *bon voyage* over the somewhat rough seas of hospital journalism.

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An important move has been made by Henry B. Platt, manufacturer of Platt's Chlorides, the Odorless Disinfectant, by placing upon the market a small size package to retail for twenty-five cents, of this old reliable and well-known disinfectant that has been in general use for over thirty-four years by



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"Stork" Sheeting

In view of the dissatisfaction experienced by many hospitals with rubber sheeting, surgeons will be glad to know that recently there has been placed upon the Canadian market a sheeting that has all the good points of the more old-fashioned rubber material, but without its faults. The fabric referred to is known as "Stork" Sheetin, which has for years enjoyed a splendid patronage from the older hospitals, particularly in Massachusetts. It gives the greatest of satisfaction on account of its wearing qualities, is not easily torn, but can be used with even greater freedom in the operating theatre than the rubber sheeting can, standing all the tests that are necessary.

"Stork" Sheetin is exceedingly pliable and has none of the coldness of the rubber goods. Apart from its suitability for the operating theatre, it is ideal for use in the nursery and as a protective to the beds of senile patients. This sheeting can be obtained from the Canadian agents, Flett-Lowndes Co., Toronto.

Elastica Floor Finish

ELASTICA is one of the floor varnishes considered by people who know all the facts.

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Neither castors nor heels mar it. Water doesn't turn it white. It needs no polishing, no retouching, as other finishes do.

Those who use it are astounded with the results of Elastica. The best of floor finishes do not compare with it. Ordinary floor varnishes look shabby in a month, but Elastica retains its fresh appearance.

Motto: Try it and see.

The Kiddie-Koop

ON another page of this issue something entirely new and equally novel is brought to the attention of hospital superintendents, doctors and nurses in the Kiddie-Koop, a piece of baby furniture that comprises a bassinette, a crib, a play pen, a caretaker and baby walker, all ingeniously combined in one article, that folds up in one operation of a second's time to a width of seven inches.

A Boon to Institution Laundries

In these days when there is considerable trouble in reference to "help" in large Institutions, any effective labor saving device is more than welcome. One such device, which will make laundry work in a Hospital easy, is

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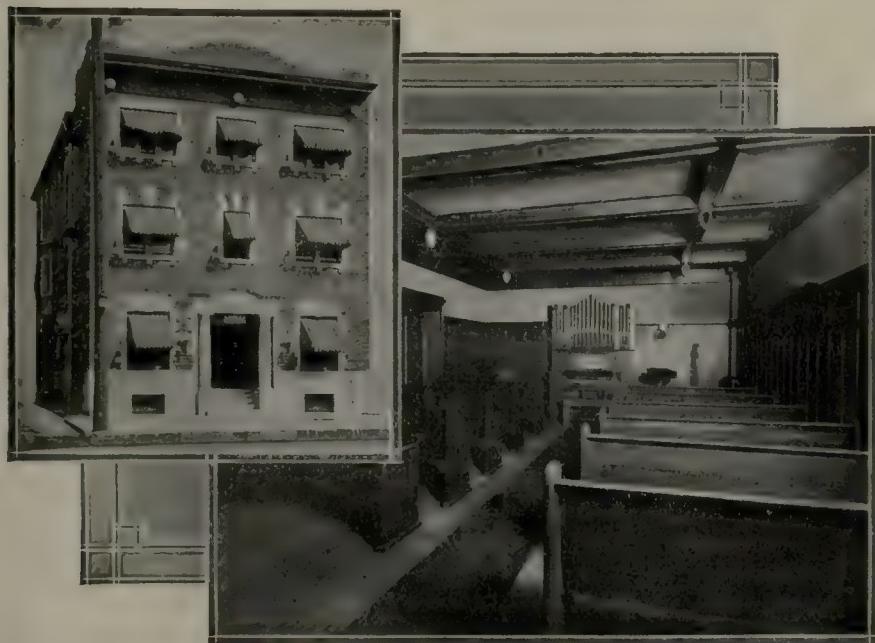
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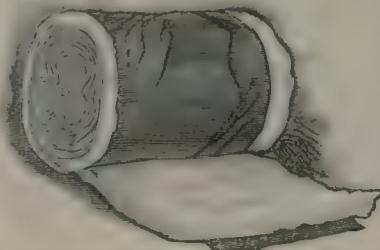
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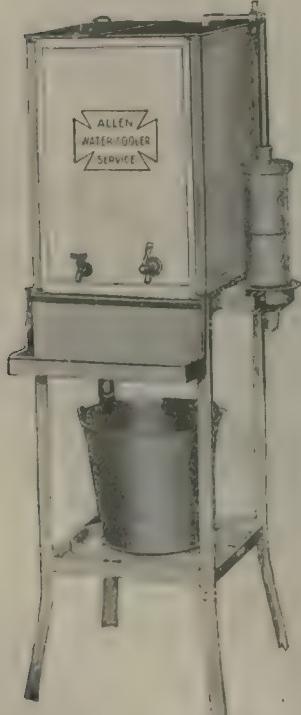


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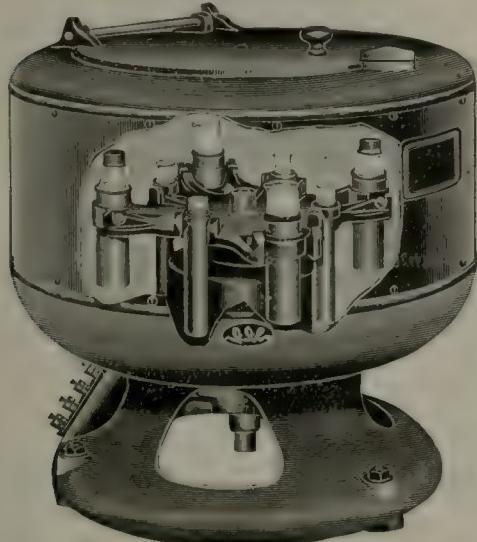
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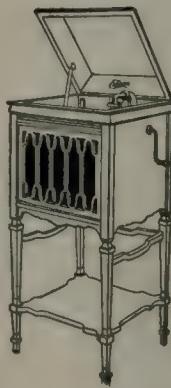
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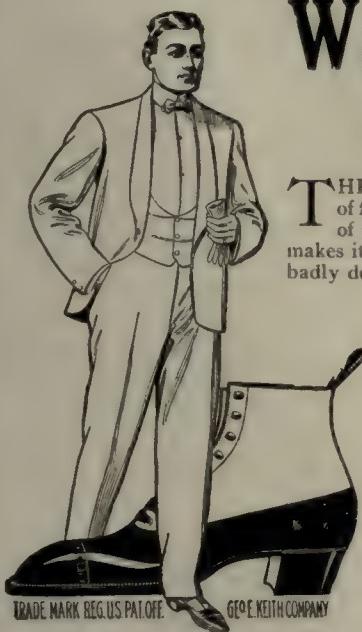
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Vol. IX (XX)

Toronto, June, 1916

No. 6

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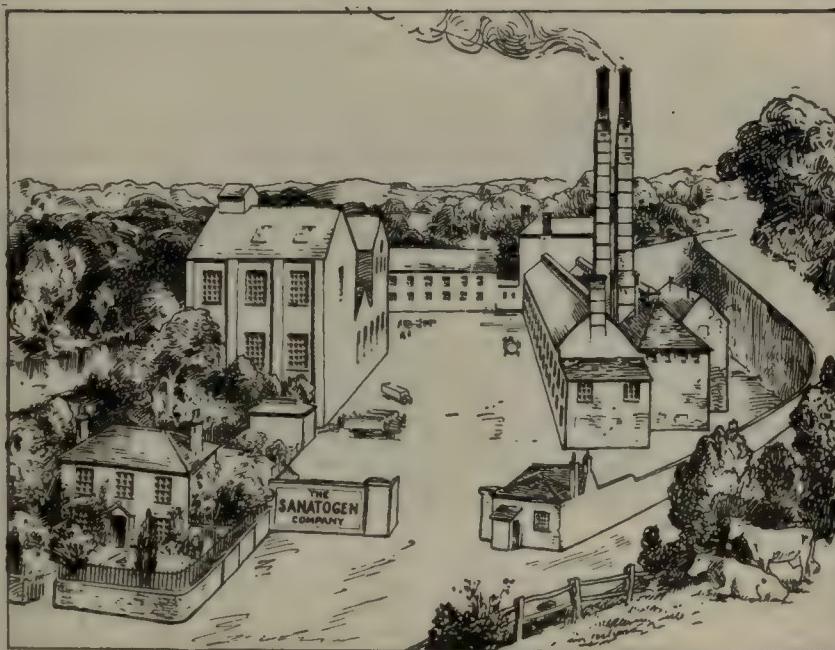
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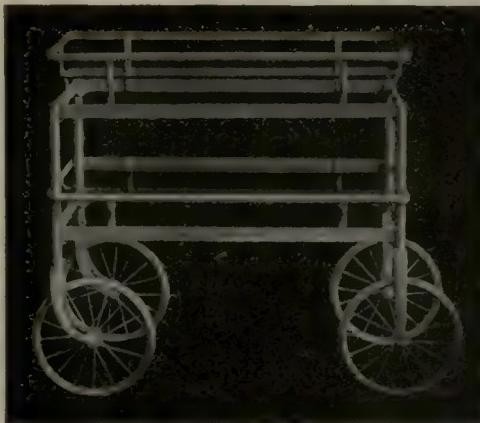
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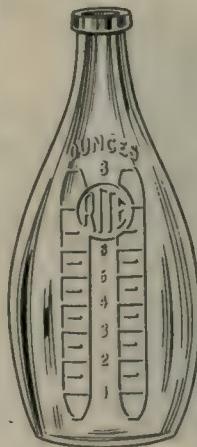
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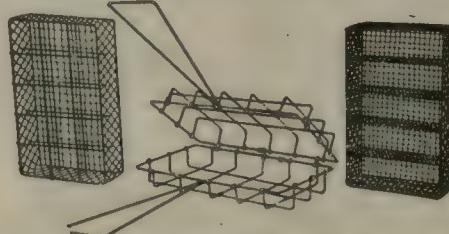
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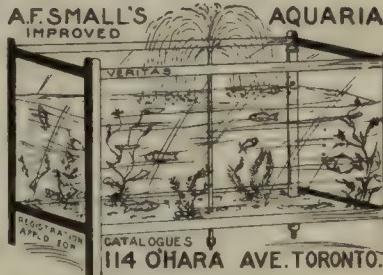
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TORONTO, JUNE, 1916

No. 6

Editorials

A BETTER WAY

IN the May number of the *American Magazine*, Dr. Richard Cabot contributes an interesting article on certain phases of present-day medical practice, in

which he points out the handicap the average general practitioner is under in studying his cases, as compared with his confrere attached to a large hospital staff. The latter is able to call to his assistance other members of the staff who are all specialists along certain lines. These gentlemen are often able to throw light on the diagnosis of any difficult case, and, if desired, assist in the treatment.

Dr. Cabot recommends the establishment of hospital centres where patients may receive examinations not only by the physician and surgeon in charge of the case, but also by the pathological chemist, the radiographer and any specialist who may be able to give expert advice. The advantage of such all-round examination to the patient is evident.

Dr. Cabot suggests that such a system might be installed through the establishment of a scheme of sick insurance, not such as prevails in England where there seems to be a scramble for the cheap doctor, or even that of Germany; but one which will enable hospitals to retain a large working staff of specialists as instanced in the famous Rochester clinic.

The writer of the article has portrayed an ideal toward which we should work.

Mr. Richard Bradley, of Boston, has been working on a somewhat similar proposition to obtain better nursing for less money; and has inaugurated a better solution of the problem of nursing people of moderate means than any hitherto suggested. This gentleman has in conception at present a sick insurance scheme for the benefit of the average family.

Probably before either of these excellent projects assume definite shape, it will be necessary to make some survey of existing conditions in order that the cost of insurance can be calculated. Some particular community must be studied; the number of cases of all kinds of sickness and disability reckoned, as well as the amount paid to doctors and nurses whose services are utilized.

A study of results thus obtained would give a clue to the amount of yearly premium required for insuring against sickness, accident and other disability, the number of physicians and nurses needed, and the cost of upkeep of such a hospital centre.

The subject is one worthy of the closest study and investigation.

THE HOSPITAL TO THE FIRING LINE

THE evolution of the military hospital is keeping pace with that of the fighting armies. The predominance of artillery over infantry charges, together with the unspeakable use of liquid gases and poisonous fire, quickly evidenced the need of more immediate skilled service than could be obtained by the process of first aid in the field and shipment to the rear for advanced treatment.

The possibility—the almost inevitable probability—of dirt infection in shrapnel wounds render immediate operation a necessity. To meet this need the equipped hospital has ceased to wait at base, but

in the form of ambulances has gone forward to the close rear of the front rank fighting lines.

In France at the present moment ambulances have ceased to be first aid and stretcher bearers only. Gradually they have become completely equipped hospitals containing laboratories, electric lights, radiograph, and other surgical requirements with also a selected staff of specialists. They are able to give all the skilled service that a permanent hospital can command—and to give it as instantly as the wounded men drop out or are carried from the first line fighting.

It became evident at an early stage of the war that the hope of the wounded lay in immediate and extensive surgery performed as near the front as possible. And this need has been met by this finely enlarged service of ambulance hospital. It is a dangerous service for the workers, but it has its reward in the saving of hours of agony and of many lives.

HELP TO BE HAD

ACCORDING to recent statement from the British War Office, a hundred and fifty new medical officers are needed in the Army monthly to meet the war wastage caused by wounds, sickness, and the dropping out of those who, having fulfilled their engagement of a year's service, feel compelled to return to their practice. Together with this diminution of the present supply, is the demand for medical oversight

of new troops constantly going forward. There is, therefore, apparently much heart-searching and questioning among British members of the profession who fall just within the age limit of service, namely, forty-five years.

The young medicals went months ago. Those also of older years whose circumstances and enthusiasms made the going easy. The remaining practitioners of middle years have domestic and money obligations to consider, which Army pay will not nearly meet. Absence from practice means serious financial loss; also the break from stable living and domestic comfort comes harder in the forties.

So it is that the sensitive, who feel keenly the obligation, are responding to the call at great personal sacrifice, while others are holding back. Our English contemporary, *The Hospital*, in discussing the issue suggests that in place of individual decision there should be a corporate decision by a professional tribunal who would sympathetically and impartially decide who should go or stay.

Such an organization carried to its furthest interpretation certainly means compulsion of medical service, and should be a last-resource device. But the compulsion would be in a sense a voluntary one authorized and endorsed by the profession itself.

Under such circumstances the question naturally arises, Why does not the British War Office avail itself of the ample medical resource afforded by the Colonies, certainly by Canada? The military

medical department at Ottawa has a long waiting list of members of the profession anxious to serve. For every hospital unit announced for overseas there are multiple more applicants for staff positions than can be placed. Why does not the British War Office draw upon the Canadian profession to fill its need?

Does it consider our men not sufficiently skilful? Does the old idea of colonial medical inefficiency still prevail? Langemarck and St. Eloi have proved Canadian valor and worth. Our infantry know their work as fighters; our medical men also know their work as healers. Physicians and surgeons both, they are not only skilful but full of a quick resource beyond that of the English conservative medical man.

Our doctors are ready—hundreds of them. If the conditions set forth by the Director General of Medical Service be true, why does not the British War Office send out the call.

ANOTHER MILITARY BASE HOSPITAL IN TORONTO

As a result of a good deal of influence brought to bear upon Toronto's Board of Control and by Council, the latter body a few weeks ago decided to rent the old Toronto General Hospital from the Hospital Trust for \$10,000 a year, and allow it to be used free of charge by the Militia Department as a Military Base Hospital. It was felt by many that, in so doing, the city was undertaking an obligation that rested

properly on the Government, but the spirit of patriotism prevailed, we are glad to know, and henceforth there will be no lack of accommodation for our brave boys when sick or wounded, for whom every consideration should and will be shown.

THE WOMEN'S COLLEGE HOSPITAL

WE congratulate the Campaign Committee who had charge of the recent whirlwind in aid of the Women's College Hospital in Toronto. The result of their efforts was indeed satisfactory, and we would have been glad had the amount realized been even greater. There is no question that Toronto should have a large modern Women's Hospital, as a great many of the weaker sex naturally prefer to have one of their own sex attend them in illness. Such a desire should not be denied them, and we look forward ere long to the formal opening of a splendidly equipped and up-to-date institution of this kind.

The first Woman's Hospital in Canada was opened in a very modest way in May, 1910, on Seaton Street, Toronto, where for years a Dispensary was conducted and is still at work. On July 17th last year, the larger premises at No. 125 Rusholme Road were opened, but have for months past been found entirely inadequate to afford treatment to the number of patients who applied for admission. The present Hospital has only twenty-two beds, of which

twelve are public ward beds. These beds have, however, accommodated no less than 199 patients during the past ten months. It is proposed to try and make the new Women's College Hospital a sixty-bed Institution, of which thirty will be public ward beds. We trust that at no distant date the Board of Directors will be able to announce accommodation for at least 100 patients.

The Officers and Board of Directors are: President, Mrs. A. O. Rutherford; First Vice-President, Mrs. F. H. Torrington; Second Vice-President, Mrs. A. B. Fisher; Secretary, Miss Janet F. Anderson; Treasurer, Mrs. F. G. Clarke; Dr. R. B. Nevitt, Mr. H. B. Gordon (Auditor), Dr. Jennie Gray-Wildman, Dr. E. L. Skinner-Gordon, Miss Lulu Fisher, Miss H. M. Robinson, Dr. G. B. Smith, Mrs. J. Baird Laidlaw, Dr. Samuel Johnston, Mrs. W. T. Harris, Rev. F. G. Plummer, Dr. Augusta Stowe Gullen, Dr. Minerva Reid, Miss Mona Cleaver, Mrs. J. Arthur Withrow, Mrs. R. A. Biggs, Mrs. R. H. Holmes, Dr. Jennie Smillie, Miss Hilda O. Rutherford, Mr. A. B. Fisher.

BRANTFORD HOSPITAL expect shortly to spend an additional sum of \$58,000 on new buildings.

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Original Contributions

PRINCIPAL ARTICLES REQUIRED TO FURNISH A HOSPITAL

BY JOHN N. E. BROWN, M.D.,

Medical Superintendent, Henry Ford Hospital, Detroit, Mich

THE articles are complied under the following heads: Furniture, Surgical Furniture, Ward Furniture, Carpets and Rugs, Beds and Bedding, Linen and Bed Clothing, Clothing, China, Crockery and Appliances, Rubber Goods, Nickel and Silverware, Tin, Hardware and Cutlery, Woodenware, Lavatory Equipment, Shades and Curtains, Miscellaneous.

Under Furniture come: Bureaus, bookcases, chiffoniers, chairs (desk), chairs (straight), chairs (Morris), desks, desk trays, foot-stools, settees, tabourettes, tables (round), tables (library), waste baskets.

Under Surgical Furniture we find: Drums, drum stands, goitre attachments, irrigating poles (continuous), instrument stands, plaster carriage, stands (observation), stands (solution), stands (immersion), stands (wall), stools (foot), stools (anesthetists'), stools (surgeons'), supply cabinets, tables (operating), tables (fracture and orthopedic), tables (dressing), tables (anesthetists'), stretchers.

Under Ward Furniture is listed: Bed (delivery), bedside tables, chairs, clothes hampers, clothes conveyors, cabinets, cabinets (medicine), dish carriers, desks (nurses'), desks (doctors'), food conveying boxes, hat trees, ine coil stands, invalid tables, surgical carriages, tray carriers.

Under Floor Coverings are listed: Rugs, carpets.

Classified under Beds and Bedding are: Beds, crib beds, cushions (wheel chair seats), cushions (wheel chair backs), cushions (steamer chair seats), cushions (steam chair backs), cushions (for prone boards), knee rolls, mattresses, mattresses (crib), pillows (hair) 20 in. by 29 in., pillows (hair) 11 in. by

16 in., pillows (feather) 20 in. by 29 in., pillows (feather) 20 in. by 27 in., couch covers, adjustable spring bottom frame, cushions (four couches), blankets (bed) 72 in. by 54 in., blankets (bed) 50 in. by 36 in., blankets (balcony) 65 in. by 57 in., blankets (balcony) 55 in. by 36 in., blankets (bath) 60 in. by 72 in., cloths (silence) diameter of 64 in., cloths (table) 81 in. by 81 in., napkins, 22 in. by 22 in., cloths (table) 48 in. by 108 in., napkins . 18 in. by 18 in., pads (mattress) 36 in. by 72 in., spreads,, 82 in. by 90 in., spreads, 27 in. by 36 in., spreads, 50 in. by 62 in., spreads, 54 in. by 72 in., towels, 30 in. by 18 in., towels, 15 in. by 18 in., towels (dressing) 26 in. by 18 in., towels (roller) 44 in. by 18 in., towels (dish) 30 in. by 18 in., towels, lavatory (30 in. by 15 in., towels, face (huck) 20 in. by 36 in., towels (bath) 20 in. by 48 in., towels (bath) 22 in. by 45 in., bath robes, students' gowns.

China, Crockery, Glassware are listed: Decorated vitrified china, butter chips, bowels (cereal), cups (dinner), cups (egg), dishes (butter), dishes (vegetable), dishes (ice cream), mustard pots, pitchers (3-quart), pitchers (2-quart), pitchers (1-quart), plates (dinner), plates (breakfast), plates (dessert), plates (bread and butter), plates (soup).

Vitrified China, plain: Bowls (soup), bowls (sugar), bowls (1-quart), cups, cups (egg), plates (breakfast), plates (tea), plates (bread and butter), plates (sauce), pitchers (cream), pitchers (1 and 2-quart), syrup jugs, saucers.

Crockery: Bowls (yellow mixing) 16½ in., bowls (yellow mixing) 12 in., bowls (yellow mixing) 8½ in., butter jars, 3-gallon, butter jars, ½-gallon, jugs (vinegar) 5-gallon, jugs (vinegar) ½-gallon.

Glassware: Bowls (fruit) 9 in., cake stands, 10 in., celery trays, 13 in., cruets (oil), cruets (vinegar), catsup jugs, cups (oyster cocktail), cups (custard), sauce dishes, sugar sifters, shakers (salt), shakers (pepper), sherbet glasses, tumblers, tooth-pick holders (footed), flower vases, 9 in.

Silverware: Butter dishes, bowls (sugar, covered), caster (two-bottle), forks (pickle), forks (oyster), forks (dinner), forks (dessert), knives (butter), knives (fruit), knives (dinner), knives (dessert), napkin rings, plate covers, pitchers

(cream), pitchers (ice water), pitchers (milk), pitchers (syrup), pots (mustard), pots (horseradish), spoons (tea), spoons (soup), spoons (dessert), spoons (sugar), spreaders (butter), sugar tongs, trays (three in one).

Surgical Supplies and Appliances is listed: Arm baths, dressing pails, dressing basins, 15 $\frac{3}{4}$ in., dressing basins, 14 in., dressing basins, 10 $\frac{1}{4}$ in., dressing basins, 7 in., dressing basins, 3 in., dressing basins, "Kidney," dressing basins, "Smith," douche pans, funnels, 3 $\frac{1}{8}$ in., foot tubs, irrigating cans, 2-quart, irrigating cans, 3-quart, jars, 6 $\frac{1}{4}$ in. by 8 $\frac{1}{2}$ in., jars, 7 $\frac{1}{2}$ in. by 9 $\frac{1}{4}$ in., jars, 4 $\frac{1}{2}$ in. by 2 in., pitchers, 3 $\frac{1}{2}$ -quart, pitchers, 2 $\frac{1}{2}$ -quart, pitchers, 1 $\frac{1}{2}$ -quart, soap dishes, sputum cups, trays (pin), 5 $\frac{1}{2}$ in. by 4 $\frac{1}{2}$ in., trays, 11 $\frac{3}{4}$ in. by 6 in., trays, 8 in. by 15 in., trays, 3 $\frac{1}{4}$ in. by 16 in. by 2 $\frac{5}{8}$ in., trays, 9 $\frac{1}{2}$ in. by 6 in., trays, 19 in. by 13 in., trays, 13 in. by 9 $\frac{1}{2}$ in., trays, 4 $\frac{1}{2}$ in. by 3 in., trays, 8 in. by 6 in., trays, 10 $\frac{1}{4}$ in. by 6 $\frac{1}{4}$ in., trays (catheter), urinals (male), trays, 10 $\frac{1}{4}$ in. by 8 in.

Glassware: Atomizers, "Spraywell," atomizers (oil), chloroform bottles, 2 oz., catheters, douche nozzles, douche nozzles (inter uterine), feeders "Ideal" glass (invalid feeding cups), finger bowls, flasks, 1-quart, flasks, 1 $\frac{1}{2}$ -quart, flasks (Kelly), graduates, 500 cc., graduates, 250 cc., graduates (Minim), glass spools, glass jars, 4 in. by 4 in., glass jars, 6 in. by 6 in., glass jars, 8 $\frac{1}{4}$ in. by 8 $\frac{1}{4}$ in., glass bottles, 2-gallon, irrigating tips, 4 $\frac{1}{2}$ in., medicine glasses, syringes, "Leur" 20 cc., syringes, "Leur" 10 cc., syringes, "Leur" .5 cc., syringes, "Leur" 2 cc., syringes (irrigating, large), syringes (irrigating, small), syringes (Sub Q), tubes (test) 6 in. by 5 $\frac{1}{8}$ in., tubes (sterilizing) 6 in. by 1 in., tubes (sterilizing) 10 in. by 2 in.

Rubber Goods: Catheters, inflators, politzer bags, rectal tubes, rubber caps, stomach tubes.

Appliances: Bed cradles, bed trucks, back rests, cranes, commodes, utensil racks for 8 urinals.

Other articles of rubber goods are listed as: Aprons (surgeons'), bags (hot water) 2-quart, bags (ice), invalid rings (adult size), Kelly pads, knee roll covers, pillow cases, sheeting (double faced) white 4-4, sheeting (double faced), maroon 6-4, sheeting (double faced), maroon 5-4.

Nickel and Silverware are listed as: Coffee pots, forks, knives, plate covers, spoons (tea), spoons (table), spoons (dessert).

Kitchen Enamelware is listed as: Double boilers, 1-quart, double boilers, 2-quart, dusting basins, face basins, kettles (tea), 4-quart, milk dippers, milk kettle, 3-quart, pans (deep pudding), pots (sauce), 8-quart, pans (Berlin, sauce), 1-quart, pitchers, 3-quart, soup ladles, serving spoons, skimmer, saucers, apple corer and parer, bread boxes, 11½ by 13 by 21, boxes (fruit), 11½ by 13 by 16, bowls (mixing), can opener, cork screws, cups (measuring), 8-ouncee, cans (sugar), cans (flour), cans (coffee), cans (flax seed), cans (tea), cans (mustard), cans (pepper), cannisters (tea), dish drainers, dredges, dishers (ice cream), engineer (ash cans), egg beaters (Dover 10 in.), egg beaters (Dover 12¼ in.), egg boiling ladles, egg boilers, 8 in., griddles (steel) 22 in., griddle cake turners, graters (heavy), graters (nutmeg), hammers, hatchets, ice picks, ice and slat scoops, ice cream can scraper, ice cream transfer ladle, ice tongs, lemon squeezers, measures, graduated 2-quart, measures, graduated 1-quart, milk pails, milk shakers, milk boilers, moulds (pudding), muffin tins, 12 cups, potato or fruit press, pans (dish) 17-quart, pans (dish) 21-quart, pans (stew), pans (biscuit, pans (frying) 9½ in. by 2 in., pans (frying, heavy), pot chains, pots (sauce), pineapple snips, potato scoops, strainers (gravy) 7-inch, strainers (Chinese), spoons (basting), steel spades, skimmers (flat), trays, 16 inches diameter, twine holders, waffle irons.

Machines are listed as follows: Apple corers, parers and slicers, bread cutter, butter cutter, cherry stoner, ham slicer, vegetable grater machine.

Agate and Enamelware is listed as: Funnel, ½-pint, funnels, 1-pint, funnels, 1-quart, pans (agate) 18 in. by 18 in., plates (cake) 10 in., plates (pie), 11 in., basins (white enamel), 16 in. by 5 in., trays (white enamel), 20 in.

Cutlery is listed as: Fish shears, forks (cooks'), forks (kitchen), forks, forks (slicer), knives (kitchen), knives (carving), knives (paring), knives (roast carving), knives (ham slicing), knives (boning), knives (bread), knives (cheese),

knives (lemon), knives (grapefruit), knives (mincing), spatula, 12 in., steels, 14 in.

Woodenware is listed as: Clothes pins, chopping bowls, boxes, 11½ in. by 14½ in., boxes (knife), boards (bread), boards (meat), 18 in. by 24 in., boards (meat), 14 in. by 21 in., boards (pastry), 20 in. by 30 in., butler's trays, butler's tray stands, brushes (grease), brushes (puree), brushes (window), brushes (radiator), bowls, 21 in., barrel covers, 21 in., cups (force), cutters (slaw), mops, mop handles, mop wringers, mop dish, mallets, roller towel racks, rolling pins, spoons (mixing), 13 in., spades, step ladders ("Hub"), 8 feet, step ladders ("Hub"), 3 feet.

Lavatory Equipment is listed as: Bath mats, medicine closets, stools, toilet paper racks, towel rods for bath-rooms, towel rods.

Window Shades are listed as: Window shades, curtains.

Miscellaneous articles are listed as: Bed pans, baskets (waste), baskets (bottle), baskets (fruit), bed trays, boards (census), boards (prone), card holders, chart holders, curtain rods, chamois skins, couches, food trucks, fracture attachments, lockers, laundry bags, laundry trucks, locks and keys, mats (desk), 21 in. by 19 in., milk boxes, natural shells, steamer chairs, supports for beds, clothes cradles, screens, tables (zinc tops), vases, wheel chairs with extension, wheel chairs (rolling), nut crackers, nut picks.

Selected Articles

REPORT ON NEW YORK CIVIC HOSPITALS

(Continued from May Issue).

B. CONCLUSIONS:

Bellevue and Allied Hospitals.

1. The difference in the amount of food used in the different hospitals of the Department of Bellevue indicates a lack of proper supervision of the distribution of food from the central storehouse to the allied hospitals. The distribution to these hospitals cannot be properly regulated without a determination of the per capita amount of each kind of food which these hospitals should receive, accompanied by a daily accounting of the amount sent to these hospitals and the amount remaining to their credit. A close supervision of this general character has not been exercised by the officers at Bellevue Hospital.
2. The failure to adjust the daily distributions of food in Bellevue Hospital to the varying number of patients and employees has resulted in either an underfeeding in certain seasons, or overfeeding in other seasons, or a waste of food. The per capita distribution of food in the months when the census was largest was probably sufficient, judging by the gross amount distributed. This leads to the conclusion that in other portions of the year the patients were overfed, or that a portion of the food was wasted.
3. The amount of meat served to the patients in Bellevue is sufficient, but the amount served to the officers and employees is excessive and accompanied by a marked waste.
4. The waste of food in the kitchens examined seemed to be due to (*a*) requisitioning more than was needed; (*b*) the preparation of all food requisitioned without regard to the number

to be served; (c) the preparation and serving of excessively large individual portions; and (d) the serving of all plates in the pantry with equal portions, irrespective of the personal tastes of those served.

5. Although gross waste has been noted in connection with the handling of food in Bellevue Hospital, the Superintendent and other officers of Bellevue are not subject to censure, owing to the fact that the hospital is undermanned and the officers are charged with more duties than they can properly perform, and also because of the fact that successful methods of controlling waste in large institutions have but recently been developed.

The Department of Bellevue has but two administrative officers. The Superintendent and the Assistant Superintendent of Bellevue are charged, not only with the supervision of Bellevue Hospital, but also that of the three allied hospitals. The supervision of the operation of Bellevue Hospital alone is a task of sufficient proportions to require the entire time of a superintendent and an assistant superintendent, and it is exceedingly difficult for two such officers to properly handle the many problems that arise in connection with the allied hospitals. It is highly probable that marked economies could be secured in the Bellevue Department if additional supervising force were provided.

Department of Public Charities.

1. The gross amount of meat received by the butcher at an institution should not exceed the net amount of meat, bone and stock delivered to the kitchens by more than 2 per cent. This 2 per cent. will account for all necessary waste in trimming and shrinkage.

2. There has been no apparent effort in the institutions of the Department of Charities to reconcile the records of the Dietitians of meat delivered to the kitchens with the records of the Storehouse of meat delivered to the institutions. The failure to reconcile such accounts has left the way clear for all sorts of waste and irregularities.

3. The large percentage of difference between the gross amount of meat received by the butcher and the amount requisitioned by the Dietitian noted in connection with Metropolitan and Kings County Hospitals indicates a lax system of accounting, and a lack of appreciation of the necessity of closely regulating the distribution of food.

4. The greater use of meat in the summer than in the winter noted in connection with some of the hospitals of the Department of Charities indicates that the Department has not maintained a definite per capita allowance, and has not taken into consideration the fact that less meat is needed in hot weather than in cold.

5. The marked difference in the supply of food per capita in the different hospitals of the Department of Charities indicates that little attempt is made to equalize the food consumption in the different institutions, and that no recognized standard of feeding is followed.

6. The administrative officials in the Department of Public Charities consist of the Commissioner of Charities; two Deputy Commissioners connected with the central office in Manhattan; one Deputy Commissioner, in Brooklyn; a General Medical Superintendent; and a Departmental Dietitian. If the duties of these various officers were properly distributed and apportioned there would seem to be no reason why the handling of supplies in the Department should not be efficiently performed and adequately checked. The facts indicate, however, that either the duties have not been properly distributed, or there has been a neglect to perform the functions assigned.

Department of Health.

1. The noteworthy difference in the supply of food per capita in Kingston Avenue Hospital and Willard Parker Hospital indicates a lack of standard for the proper feeding of patients. The fact that Riverside Hospital, which cares for tuberculous patients and some cases of mixed contagion, uses considerably more food per capita than the Otisville Sanatorium,

which cares for tuberculous patients only, indicates that insufficient attention has been given to the proportions of food needed by different classes of patients.

The above conclusions are based on the food records of the Department for the year 1912. The findings of the Committee were placed in the hands of the Commissioner of Health early in the year 1913, and the irregular distribution and consumption of food noted in this report have been, in a large measure, corrected.

C. RECOMMENDATIONS:

Bellevue and Allied Hospitals.

1. The Dietitian should be made responsible for determining the total amount of the various kinds of food needed for the Hospital.

2. The Dietitian should requisition all food on the basis of an actual count of both patients and employees, and the amount requisitioned for any particular day should be based upon the actual count on the second day preceding the day on which such requisitions are issued.

3. A per capita allowance of each kind of food should be established for patients and officers and employees. The aggregate amount of each article of food needed for the year should be based upon the daily per capita allowance. The requisitions should adhere strictly to the established allowances, and should be made to apply to the allied hospitals as well as to Bellevue Hospital.

4. A basic dietary table similar to that recommended on page 40 should be established, and, in connection therewith, a system of separating and weighing waste similar to that described on pages 37 to 39 should be installed. The basic dietary table should be corrected from time to time, according to the finding of waste of the various articles of food.

5. A business manager should be provided for the Department of Bellevue. The function of such manager should be to

determine the kinds, causes, and amounts of supplies to be used, and to supervise their distribution and consumption. He should also have supervision of the care of the buildings and the employment of the help, and perform the functions of the former purchasing agent. His salary should be not less than \$4,000 a year and maintenance.

6. A schedule of the yearly per capita proportions of food for use in general hospitals is set forth on page 42. It is recommended that this be adopted as a basis for estimating the amounts of the various kinds of food needed for the year.

7. A monthly statement similar to that shown opposite page 44 should be placed before the Superintendent of each institution and the General Superintendent, to inform them as to the proportions of the various kinds of food that are being used; the proportion of the budget allowance that has been consumed; and the amounts of food elements that have been supplied.

8. If the above recommendations are put into effect the saving in food cost alone in the Department of Bellevue should be not less than \$30,000 a year, compared with the cost in 1912.

Department of Public Charities.

1. The Dietitian should determine the average percentage of fat, bone, and trimmings that should be cut out of each carcass by the butcher in cutting up the carcass for delivery. Memoranda should be kept to see that these proportions are adhered to.

2. The distribution records for meat should be recapitulated not less than once a week, and placed in the hands of the Dietitian for comparison.

3. There should be no substitution of meats for the specific kind ordered by the kitchen, except by order of the Dietitian authorizing such substitution, which substituted order should be entered in the records.

4. The supervising Dietitian should be made responsible for determining the total amounts of the various kinds of food

needed for each hospital and for each almshouse. These amounts should be based upon established schedules. It is recommended that a schedule similar to that set forth on page 42 be adopted for the general hospitals, and that the schedule set forth on page 43 be adopted for the almshouses.

5. The Dietitian should requisition all food on the basis of an actual count of both patients and employees, and the amount requisitioned for any particular day should be based upon the actual count on the second day preceding the day on which such requisitions are issued.

6. A basic dietary table similar to that recommended on page 40 should be established, and, in connection therewith, a system of separating and weighing waste similar to that described on pages 37 to 39 should be installed. The basic dietary table should be corrected from time to time, according to the finding of the amount of waste of the various articles of food.

7. A monthly statement similar to that shown opposite page 44 should be placed before the Superintendent of each institution and before the Commissioner of Charities, to inform them as to the proportions of the various kinds of food that are being used; the proportion of the budget allowance that has been consumed; and the amounts of food-elements that have been supplied.

8. If the above recommendations are put into effect the saving in meat cost alone in the hospitals of the Charities Department should be not less than \$13,000 per year, compared with the cost in 1912.

Department of Health.

1. It is recommended that the Department of Health use a schedule similar to that set forth on page 42 as a basis for the budgetary estimate of food needed for an ensuing year in each of the institutions caring for cases of mixed contagion, and also for institutions caring for tuberculous patients. This schedule is submitted only as tentative, and should be modified by the

experience of the Department, after careful study of the needs of each class of patients.

2. A basic dietary table similar to that recommended on page 40 should be established, and in connection therewith, a system of separating and weighing waste similar to that described on pages 37 to 39 should be installed. The basic dietary table should be corrected from time to time, according to the finding of the amount of waste of the various articles of food.

3. A monthly statement similar to that shown opposite page 44 should be placed before the Superintendent of each institution and before the Commissioner of Health, to inform them as to the proportions of the various kinds of food that are being used; the proportion of the budget allowance that has been consumed; and the amounts of food-elements that have been supplied.

THE CARE OF WOUNDED SOLDIERS

The following succinct account of the method of receiving and caring for the wounded soldiers arriving in Great Britain is taken from a recent issue of a medical journal in Great Britain in the belief that it will be of interest to Canadian hospital workers:

"The wounded are conveyed as rapidly as possible from the front to the base hospitals in France on the coast, whence they are conveyed by hospital ships to Southampton, where there is a special staff for their reception and distribution. The arrangements are under the control of a surgeon-general, who holds the appointment of a deputy director of medical service. He has at his command twelve ambulance trains specially constructed for the conveyance of four officers and ninety-six men lying down, or for a considerably greater number of patients sitting. Twice weekly telegrams are received by him from all the larger military and territorial force general hospitals, stating the number of beds vacant in each. With this information before him he arranges convoys of sick and wounded on arrival and

dispatches them to their destination in one or more of the ambulance trains. Already the sick and wounded from overseas have been comfortably placed under treatment in most of the large military or territorial force hospital centers. At the railway stations of these localities arrangements are made by the military authorities for conveying sick and wounded in motor or other ambulance vehicles from the railway stations to the hospitals. Voluntary aid detachments have already done useful work in connection with this stage of the movements of the sick and wounded, and it is expected that the scope for utilizing voluntary aid in this direction will be extended as its value becomes better known. As the military hospitals get filled up arrangements have been made for transferring sick and wounded from them to various hospitals arranged by voluntary effort. Many schemes have been submitted to the War Office, through the British Red Cross, in accordance with field service regulations. At present the opportunity of using private hospitals to any great extent has not arisen, as there are still several thousand beds vacant in the military and territorial force hospitals. There is no doubt, however, that in time private hospitals will be of much use as an overflow, and also when it is necessary to set free a sufficient number of beds for future requirements in the larger military hospitals. When sick and wounded are sufficiently convalescent to be granted sick furlough, advantage is being taken of the many offers of accommodation for them in convalescent homes in different parts of the country. In order to prevent overlapping and to facilitate the means of placing men on sick furlough, so far as possible, in their own counties, a central registry of convalescent homes has been formed. Convalescents who require continued hospital treatment will be sent either to the special home in connection with the hospital from which they are transferred (under the supervision of the medical officer of the hospital) or to one or other of the private hospitals already referred to. In all the hospitals arrangements are made for replenishing any deficiencies in the men's kits and for giving them any additional clothing which it may be desirable for them to take with them when they go on sick furlough. The hospitals are for this purpose

receiving many generous gifts of pajama suits and other articles of clothing. At the end of their sick furlough the men are required to rejoin the depots of their regiments in order to be refitted, until arrangements are made for their rejoining their units, either in this country or abroad. They are provided with railway warrants to enable them to go to convalescent homes and to rejoin their depots. Arrangements have also been made that they shall receive their pay both while they are in hospital and while they are convalescent.

PROFESSIONAL ETHICS

IN the earliest day, when mankind first began to congregate into communities, it became necessary to establish rules and limits to prevent the wants of the one overstepping the rights of the other. A few simple maxims sufficed for the needs of primitive times and conditions, and the decalogue furnishes of this an example. But even this code shows evidences of development, for the last commandment betokens a state of mental growth where motives were recognized as culpable, as well as actions; and the first four denote the rise of a priestly cult. Excluding these, we have the first needs of men as members of a community—security of life, property, wives, the denunciation of lying, and that veneration for parents that justifies the latter in making their sacrifices for the children.

The increase of population brought complexities demanding the increase of regulation, until now the law is so unwieldy and complicated that not the most erudite of its devotees can always be sure of his opinions as to what is really law. Admitting that a man sincerely desires to do what is right, it may be a difficult or even impossible matter to say exactly what is the right. This also depends upon what is the standpoint of him who seeks to make the decision. What does one mean by the "right"?

Some content themselves with restraint within the bounds of the legally right—so long as they kept out of jail they let it

go at that. Two men go into partnership and deposit their funds in a bank. One of them draws out the money and keeps it. Legally right, to be sure, for the law says it would be impossible for business to be transacted unless each partner were allowed this right. But it surely does not tally with the ethic standard of him who looks at such matters from the moral point. With the latter, the question is neither as to the legality nor the permissibility of a matter, but as to its righteousness.

The right or wrong of an action goes far deeper than its legality. Conscience rules instead of legal enactment. True, the consciences of men differ, and sometimes they make men play strange antics. The Boers read nothing but the Bible, and applied to themselves the savage exhortations given to the Hebrews as to exterminating the Canaanites, root and branch. It was no small part of their grievances against the English that the latter would not suffer the Boers to obey their consciences and exterminate the Kaffirs. Men can persuade themselves that almost anything they want to do is a duty. Nearly every man who begins the treatment to enable him to desist from the morphine habit, when he reaches a certain point and feels the craving for that drug, begins to persuade himself that it is his duty to go home and work, to do something or anything that will excuse his taking a dose.

Beyond the legal and the moral there comes the consideration of the rules and limits established by "society." It is neither illegal nor immoral for a man to go barefooted in the street of a city, but society forbids. Custom and the professional ethics forbid the physician's advertising for patients, and the transgression of this rule excludes him from the more elevated circles of his profession. In fact, a physician may be a drunkard or immoral, and yet pass muster, provided he does not advertise.

From these various codes results a sad jumble. In the medical profession may be found men who would not advertise in a newspaper, but who exercise their ingenuity to secure every form of advertising that would not bring them under the ban. Illustrated interviews may appear in the daily papers, but not an openly paid advertisement. The most eminent members are those who can come the nearest to the prohibited line without

actually passing it. There also are men who do not hesitate to take the last dollar from their patients for operations totally unnecessary—yet these men are strictly ethical.

On the other hand, there are physicians, regular graduates of the most reputable colleges, legally registered, who travel over the country and insert their pictures and advertisements in the papers. They may do an honest business, never taking a dollar they do not fairly earn, doing good professional work, holding the confidence of patients for many years, and yet they are not ethical, although their business is legal and moral.

The one class consists of legal and ethical, but immoral scoundrels; the other, of men who are ethically moral, but legal outcasts.

I do not defend these men. The ethic standards of the profession are wise and just; but they should be superadded to legality, morality, and something beyond these—altruism. The confidence reposed in the physician is so absolute, so necessary to his duty, that he must adhere to a higher standard than any other men. He must not let the question of monetary reward influence his advice. The only consideration before him is the best interests of his patient.

There is presented, therefore, an intermixture of all the various standards mentioned, with a tendency to the legal—"do anything so long as you are not caught." Here we have the discipline of ancient Sparta repeated in modern times. The Spartan boy was taught to steal but not to permit himself to be caught, the theft being looked upon as creditable in itself.

There seem to be many Spartans among moderns. In boys' schools a similar sentiment prevails largely, and they "swipe" each others' goods without compunction, the victim being adjudged to take better care of his effects in future. In legal circles the maxim "*caveat emptor*"—the buyer must care for his own interests—is an acknowledged principle.

Summing the matter, our advice to the new doctor should be:

Be honest. Keep your conscience clean. Do nothing you might fear the whole world to know. Do nothing you might fear your wife to know. Do nothing that would make you fear to face your final account on the Great Day.

Be ethical. It is not worth while to forfeit the esteem and respect of the most ethical of the profession. Professional standing is like a woman's honor—its value is never so apparent as when it has been lost. Men have postponed being ethical until they have "made their pile," only to find that they would willingly give it all to find themselves again within the pale. Better endure poverty for a time, knowing that true worth must surely be recognized; and exercise your wits to hasten that day, rather than lose what can never be replaced afterward. We know one man, very ethical to-day, very "swell," who yet lives in "dread that somebody may one day make public the fact that when young he used to have in the newspapers of a neighboring town the paid announcement that he "stood for a season" each week at the hotel. About this way: "Dr. White, the distinguished Chicago specialist in diseases of the eye, ear, nose and throat, will be at the Nevertell Hotel of this city on Mondays and Wednesdays."

Be diligent in business, and get your finances upon a solid foundation by the good old method of doing your work so well that it advertises you; by keeping your expenses within your income; by avoiding a display that wastes your substance and piles up debt, without deceiving anybody; and by finding methods of becoming acquainted and making friends that are yet honest and ethical. How? My dear boy, what are your brains for?

Still further, over, and beyond all this, keep in mind that Eleventh Commandment, that embraces and supersedes all the rest; love God and love your neighbor.—*Am. Jour. of Clin. Med.*

THE CAMPAIGN AGAINST CANCER IN NEW ENGLAND

THE New England States generally show a higher death rate from cancer than any other group of states. This does not mean that New England people are more susceptible to this disease. Cancer is a disease of later adult life and it is well known that in parts of New England there are more old people proportionately to the population than in many other regions. Nevertheless, the death rates recently published by the United States Census Bureau have stimulated much activity in these states in the educational campaign for the control of malignant disease.

What are the facts upon which this movement is based? According to the report of the Census Bureau, in 1913 there were 49,928 deaths from cancer in the registration area of the United States, corresponding to a death rate of 78.9 per 100,000 of the population. All the New England States have individual cancer death rates much higher than this. Connecticut's rate, which was the lowest of any of the New England States, was 85.1. Vermont's rate was the highest, with 111.7, while the rates of the other states were correspondingly high, Maine having a rate of 107.5, New Hampshire 104.4, Massachusetts 101.4 and Rhode Island 93.3. When these figures are compared with those of Kentucky, with a rate of 48, they seem indeed very high. They mean that 6,817 people died in 1913 in New England from cancer. But it does not necessarily follow that cancer is more common in New England than elsewhere. The Census Bureau attributes the high cancer death rates in certain districts to the relatively high age distribution of the population and the negligible amount of immigration. Translated into everyday terms, this means that in New England the proportion of people over forty years of age, or at the cancer age, to those under forty, and so less liable to cancer, is greater than in other places. Yet there is no doubt that the cancer death rate in New England as well as in other parts of the country is much higher than it ought to be. Without ques-

tion a large percentage of cancer deaths can be prevented by early recognition of the symptoms and prompt recourse to competent surgical advice and treatment. Cancer is not a hopeless incurable affection, as so many people wrongly believe. Those who know the facts, believe that if the public can be properly educated in regard to the early signs of the disease and will act on this knowledge, the present mortality should be reduced at least half and perhaps two-thirds.

That New England is awake to this opportunity of saving lives is evident from the activity in several states. To protest against taxation without representation the patriots of Massachusetts dumped overboard the famous cargo of tea. Vermont medical men have become so concerned over the high cancer death rate of their state that they are going to hold a "tea-party" of another sort and attempt to dump overboard the high death rate from malignant disease. While their action is not so dramatic as that of the patriot raiders they hope to prove that through its great ultimate benefit to the community it will be almost as patriotic. The New Hampshire State Board of Health has recently published sound advice in its Bulletin. In Maine an active committee of the State Medical Society is arranging public lectures and causing the publication of instructive articles in the newspapers. Massachusetts has a well-organized branch of the American Society for the Control of Cancer, with headquarters in Boston. The Vermont State Medical Society has arranged a series of public meetings to spread the bad news of the high cancer death rate and the good news of the hope of controlling the disease by earlier recognition and prompt surgical treatment. Morning, afternoon and evening meetings will be held on Tuesday, Wednesday, Thursday and Friday, June 8th to 11th, at Rutland, Burlington, Montpelier and St. Johnsbury. The Vermont State Board of Health will send its Secretary, Dr. Charles F. Dalton, to address each of these meetings, and the American Society for the Control of Cancer will be represented by Dr. Francis Carter Wood, Director of Cancer Research at Columbia University, New York City, and by Dr. J. M. Wainwright, Chairman of the Cancer Committee of the Pennsylvania State Medical Society.

Hospital Notes

A New Wing for the Toronto Free Hospital

A NEW wing is to be erected at the Toronto Free Hospital for Consumptives at Weston to accommodate about forty patients. A cottage, the gift of Mr. William Davies, of this city, to supply further accommodation for the little patients at the Queen Mary Hospital is also to be erected.

Another Military Convalescent Hospital

THE Convalescent Hospital for Officers, Jarvis and Wellesley Street, the gift of Mrs. H. D. Warren, was informally opened on April 21st, when the Lieutenant-Governor, Sir John Hendrie and Lady Hendrie, Brigadier-General and Mrs. W. A. Logie, Lieutenant-Colonel T. B. Richardson and other officers were entertained by Mrs. Warren and Miss Warren at tea in the hospital.

Lieutenant-Colonel Marlow, A.L.M.S., was represented by Major C. A. Warren, Deputy A.D.M.S.

New Canadian Officers' Hospital Opened in London

THE new Canadian Officers' Hospital in Hyde Park Terrace was opened on May 11th by Princess Louise. Also present were Hon. Arthur Stanley, Sir George and Lady Perley, Mrs. Walter Barwick, Toronto, General Jones and Colonel Hodgetts. Mrs. Barwick presented the Princess with a bouquet. Then the Princess, after viewing the hospital, declared it open. In the drawing-room Colonel Hodgetts thanked Colonel and Mrs. Gooderham for their gift. After the war the hospital fittings will be presented to the Star and Garter. Hon. Mr. Stanley spoke, formally accepting for the Red Cross, and said that one ward will be named after the Daughters of the Empire. Sir George Perley and General Jones followed with short speeches.

Word from Orpington Hospital

WE recently received the following interesting notes from a member of the Staff of the Ontario Base Hospital, now settled comfortably at Orpington, Kent, England.

"We are now at Orpington Hospital, which is, in point of equipment, one of the finest in the Empire. The hospital at Orpington is situated in a town of about 6,000 people, and everything around it is perfectly beautiful. We arrived in Halifax on April 1st, embarking on His Majesty's transport No. 2,810, formerly the *Olympic* of the White Star Line. We had 6,900 troops and 1,000 of a crew. We lay in the harbor until Wednesday. On board with us were the 67th Battalion, Western Highlanders; the 61st, Winnipeg; the 71st, Guelph; the 59th, Oshawa, and artillery from Kingston and Halifax. Shortly after getting under way the crew lowered all lifeboats and there they swung for the rest of the voyage. All portholes are painted black, and at night the big boat goes along without a light showing, and all aboard are compelled to wear large life-belts, except when in bed, when they are hung at the head of the bed.

"Sunday morning, April 9th, we entered the war zone, and the big vessel, as we had no convoy, zig-zagged from side to side and travelled at a tremendous speed. I visited the stokers and saw 140 men shovelling coal with all their might. Everyone on board naturally was very uneasy, and on Monday the 11th, were all lined up by lifeboats ready to take to the water. We were then told at twelve noon we were to be met by two of the fastest submarine destroyers in the British navy, and at exactly eight minutes to twelve these terrors to submarines crossed our bow, and, oh, you don't know how glad we were to see them. There they stayed, both flying the Union Jack, and we realized at last that it is no idle boast that Britain rules the waves. We came in sight of the south coast of Ireland and in the home of the German submarines, but British destroyers and trawlers just shot all around, and no submarine dared put in an appearance. One did appear behind us and was wrecked by one shot from a British gun. Then one appeared ten miles ahead of us, and six destroyers shot after it, and that was the

end of alarms. By night we could see the green Emerald Isle very well, and on Tuesday morning, April 11th, we entered the Mersey River, and our convoy of destroyers bade us farewell."

Guelph Doctor Appointed

THE Board of Governors of Kingston General Hospital have appointed Dr. J. A. Boyd, Guelph, as Medical Superintendent, to succeed Dr. M. F. Coglon.

The Henry Ford Hospital

IN a recent number of the *Trained Nurse* there appears a brief article on this hospital. It says, among other things:—

The Henry Ford Hospital had its beginning in the plans for the Detroit General Hospital, which was designed to be a great medical and teaching centre. Before the construction work had proceeded far, disputes arose as to plans and policies, and progress was at a standstill for some time, till Mr. Ford finally agreed to complete the enterprise and return all money contributed toward it to the contributors. Since that time the construction has proceeded without interruption, and the first group of buildings was completed a few months ago. Through all this period, Dr. J. N. E. Brown has been in charge, supervising every detail of construction and equipment, and the result, as seen in the completed buildings, is due in large measure to his patient working out of the multitudinous problems that have had to be met, to his assiduous attention to details, to his years of study and wide knowledge of hospital construction and equipment, and to his general ability to meet difficulties and smooth out tangles. Whoever the man may be who has the task of completing the last of the buildings, the credit for the completeness of the first group belongs largely to Doctor Brown, though he is far too modest to claim the credit that is his due.

Several months ago Dr. Frederick J. Smith, of Baltimore, was appointed resident physician of the hospital, and an erroneous report was circulated that he had become the superintendent.

Book Reviews

The Practitioners' Medical Dictionary, containing all the words and phrases generally used in Medicine and the allied sciences, with their proper pronunciation, derivation and definition. By GEORGE M. GOULD, A.M., M.D. Third edition. Revised and enlarged. By R. J. E. SCOTT, M.A., B.C.L., M.D. Philadelphia: P. Blackston's Son & Co.

In announcing the presentation of this dictionary the publishers say they have aimed at producing a low-priced dictionary (\$2.75), up-to-date and easy to handle. The book consists of xx-962 pages, is bound in flexible cloth, has rounded corners and marbled edges. It contains some 80,000 terms, all in clear, readable type, clearly and concisely defined. This handy volume —8 $\frac{3}{4}$ inches high, 6 $\frac{1}{4}$ wide and 1 $\frac{1}{4}$ thick—should find a wide sale.

Painless Childbirth, Eutocia and Nitrous Oxid-Oxygen Analgesia. By DR. CARL HENRY DAVIS, Associate in Obstetrics and Gynecology, Rush Medical College, Assistant Attending Obstetrician and Gynecologist to the Presbyterian Hospital, Chicago. Chicago: Forbes & Co. Price, \$1.00.

This timely little book places before the medical profession tersely many vital facts in obstetrics which should drive home with sledge-hammer blows the realization that even to-day a woman has not invariably given to her, in her confinement, that safety to life and health, as well as comfort and relief from pain, which she has a reasonable right to expect. The author unflinchingly places much of the blame where it belongs, viz.: on careless and inefficient midwives, male and female.

Not only should a woman have as great care in her confinement as does a major surgical operation case, but also she should be protected from surgical shock as does a thyroidectomy patient. The author shows how motherhood can and should be

robbed of its physical and mental anguish and pain without danger to mother or child, by the skilful administration of nitrous oxide and oxygen analgesia, which does not cause in the maternal organism those pathological changes produced by chloroform and to a lesser extent by ether, nor render difficult the maintaining of asepsis, as occurs when Twilight Sleep is given.

The Psychology of Relaxation. By GEORGE THOMAS WHITE PATRICK, Ph.D., Professor of Philosophy, University of Iowa. Boston and New York: Houghton-Mifflin Company. 1916.

On the flyleaf of this little volume appears the following:—

“I ain’t gwine a work till my dying day;
'F I ever lays up enough
I's gwine a go off a while en stay,
I'll be takin' a few days off.
Case de jimson weeds don't bloom but once.
En when dey's shed dey's shed.
En when you's dead, tain'tjis a few mont's
But you's gwine be a long time dead.”

The author agrees with the theory of Professor Groos, who maintains that play, laughter, profanity, alcohol, war, act as a sort of *Catharsis*—a safety-valve for the expression of pent-up emotion—which bring relief from that peculiar form of fatigue which follows from our modern strenuous life. These forms of diversion rest those parts of the nervous system which our daily work most stresses.

This is the theme upon which the author works. To all students interested in practical psychology this volume will be found of great interest. A complete bibliography is presented.

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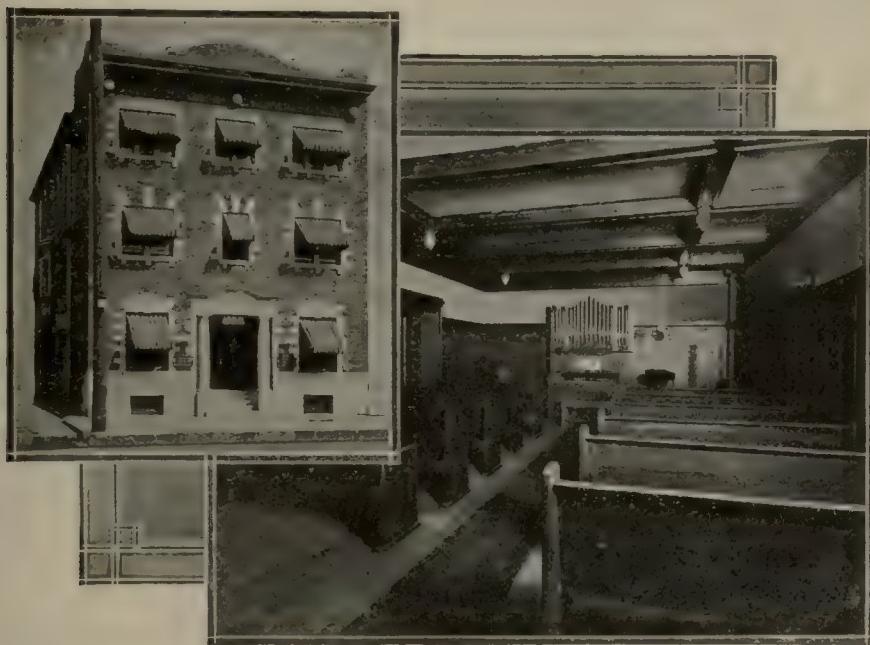
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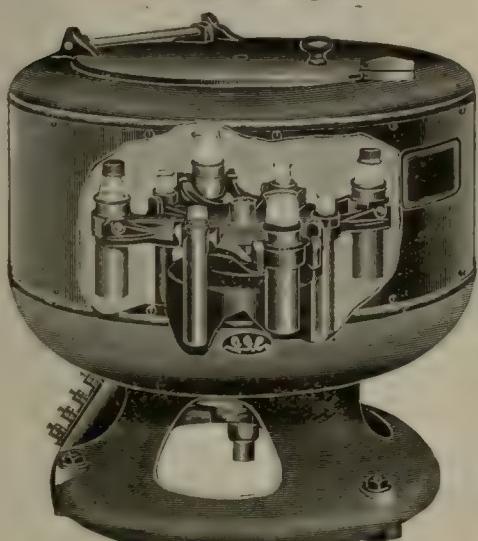
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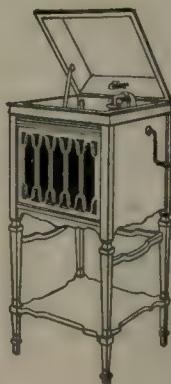
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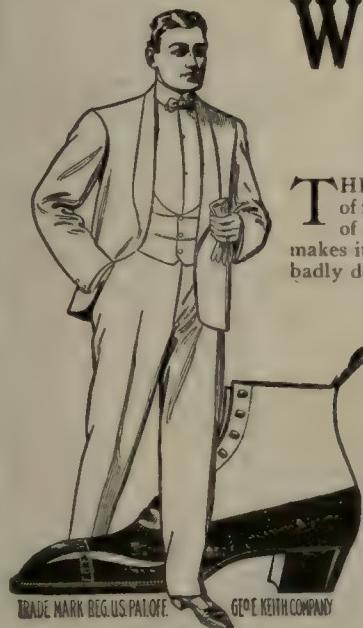
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